STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027386

[redacted]

Dear [redacted],

On March 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 15, 2017 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

This page intentionally left blank.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: March 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027386

[redacted]

Issue

The issues presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine you were eligible to receive up to $229.00 per month in advance payments of the premium tax credit and ineligible for cost-sharing reductions, effective January 1, 2018?

Procedural History

On November 14, 2017, NYSOH received an application for financial assistance with your health insurance.

On November 15, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $229.00 in advance payments of the premium tax credit (APTC), effective January 1, 2018. The notice indicated you were not eligible for Medicaid, the Essential Plan, or to receive cost-sharing reductions, because your annual household income was over the allowable income limits for those programs.

Also on November 15, 2017, NYSOH issued an enrollment notice confirming your enrollment in a Bronze level qualified health plan, effective January 1, 2018.

On January 18, 2018, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination notice insofar as you were not eligible for an increased amount of financial assistance.

On March 21, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit wherein your daughter appeared on your behalf as a witness. The record was developed during the hearing and closed thereafter.

Findings of Fact

A review of the record supports the following findings of fact:

1) You are seeking insurance for yourself.

2) You testified that you expect to file your tax return for 2018 with a tax filing status of married filing jointly and you will claim no dependents on that tax return.

3) An online application was submitted on your behalf on November 14, 2017. You testified that you completed the application with the help of your daughter.

4) That application listed your expected annual household income for 2018 as $41,080.00 consisting of $25,480.00 your spouse would earn through her employment and $15,600.00 you would receive from six Social Security benefit payments of $2,600.00.

5) Based on the information in your application, NYSOH determined you eligible for $229.00 in APTC.

6) You enrolled in a bronze level qualified health plan with APTC applied to the monthly premium, effective January 1, 2018.

7) You appealed insofar as you were not eligible for more financial assistance with your health insurance.

8) Your daughter testified that at the time your November 14, 2017 application was submitted, you had not yet received your Social Security disability award letter, so you did not know how much you would be receiving in benefits in 2018.

9) You testified that you began receiving Social Security benefits in November 2017. You testified that you will receive a Social Security benefit payment in each month in 2018 in the amount of $2,650.00.

10) You testified that you also began receiving a pension in January 2018.

11) You testified that you will receive a pension payment in each month of 2018 in the net amount of $1,800.00. You testified that the gross amount of your pension payment was approximately $2,450.00 monthly.

12) You testified that the income information in your application regarding your spouse's income was still accurate.

13) You testified that you are seeking more financial assistance with your health insurance, because your current plan has a 50% co-pay which makes medical treatment unaffordable.

14) You testified, and your application indicates, you reside in Richmond County.

15) You testified, and your application indicates, you will not take any deductions on your 2018 tax return.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (*see* 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id*.).

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return

and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

The maximum amount of APTC that can be authorized equals:

1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

minus

2) the taxpayer's expected contribution amount

(*see* 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Federal Register 8831).

For annual household income in the range of at least 250% but less than 300% of the 2017 FPL, the expected contribution is between 8.10 % and 9.56 % of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

<u>Cost-Sharing Reductions</u>

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan through NYSOH, (2) meets the requirements to receive

APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level qualified health plan (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Legal Analysis

The issue is whether NYSOH properly determined you were eligible to receive up to $229.00 per month in advance payments of the premium tax credit and ineligible for cost-sharing reductions, effective January 1, 2018.

On November 14, 2017, NYSOH received an application for financial assistance with your health insurance. That application listed your expected household income for 2018 as $41,080.00 and the subject eligibility determination relied upon that information.

You are in a two-person household, because you expect to file your 2018 income tax return as married filing jointly and will claim no dependents.

You reside in Richmond County, where the second lowest cost silver plan available for an individual through NYSOH costs $509.30 per month.

An annual income of $41,080.00 is 252.96% of the 2017 FPL for a two-person household. At 252.96% of the FPL, the expected contribution to the cost of the health insurance premium is 8.19% of income, or $280.24 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county ($509.30 per month) minus your expected contribution ($280.24 per month), which equals $229.06 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you eligible for up to $229.00 per month in APTC.

Additionally, NYSOH properly found you ineligible for cost-sharing reductions, because your annual household income, according to the information in your application, of $41,080.00 is 252.96% of the applicable FPL which is over the 250% limit to qualify for cost-sharing reductions.

Therefore, the November 15, 2017 eligibility determination notice stating you were eligible to receive up to $229.06 in APTC and ineligible for cost-sharing reductions was correct, based on the information in your application, and is AFFIRMED.

However, it is noted that during the hearing, you and your witness testified that you are actually receiving more income in 2018 than reported in your November

14, 2017 application. Based on your testimony that in 2018 you will receive 12 monthly Social Security benefit payments of $2,650.00 as well as 12 monthly pension payments in the gross amount of $2,450.00, the evidence establishes that you have expected annual income for 2018 of $61,200.00. Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a two-person household and the now developed record establishing your annual expected household income for 2018 is $86,680.00. including $61,200.00 in gross income you will receive in 2018 as well as $25,480.00 your spouse will receive.

Decision

The November 15, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a two-person household and the now developed record establishing your annual expected household income for 2018 is $86,680.00.

Effective Date of this Decision: March 26, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance going forward, based on your testimony of your current income.

You will receive an updated eligibility determination notice from NYSOH.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Summary

The November 15, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a two-person household and the now developed record establishing your annual expected household income for 2018 is $86,680.00.

You will receive an updated eligibility determination notice from NYSOH.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).