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

Notice of Decision

Decision Date: May 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029320

[redacted]

Dear [redacted]

On April 17, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 1, 2018 eligibility determination notice and February 1, 2018 disenrollment 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 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).

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

Decision

Decision Date: May 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029320

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you and your older child were eligible to receive up to $462.00 per month in advance payments of the premium tax credit, and that you were ineligible for cost-sharing reductions, effective February 1, 2018?

Procedural History

On November 22, 2017, NYSOH issued a notice of eligibility determination stating that you and your older child were eligible for up to $546.00 per month in advance payments of the premium tax credit (APTC) and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, both for a limited time, effective January 1, 2018. This notice directed you to submit documentation of your household income by February 19, 2018 in order to confirm your eligibility for financial assistance.

On December 16, 2017, NYSOH issued a notice of enrollment confirmation stating that you and your older child were enrolled in a parent and child qualified health plan with a plan enrollment start date of January 1, 2018. Your monthly premium was $807.43 to which your APTC of $546.00 was applied as of January 1, 2018 for a monthly premium responsibility of $261.43.

On January 30, 2018, income documentation was uploaded to your NYSOH account.

On January 31, 2018, NYSOH verified the income documentation you submitted, recalculated your household income, and submitted an updated application on your behalf.

On February 1, 2018, NYSOH issued a notice of eligibility determination, based on the January 31, 2018 application, stating that you and your older child were eligible for up to $462.00 per month in APTC, effective February 1, 2018, and that your older child was eligible for cost-sharing reductions if he enrolled in a silver level qualified health plan, effective February 1, 2018. This notice stated that you were ineligible for cost-sharing reductions because your household income was over the allowable income limit for that program.

Also on February 1, 2018, NYSOH issued a disenrollment notice stating that your older child's enrollment in his qualified health plan would end on January 31, 2018. This was because he was no longer eligible to remain enrolled in his qualified health plan.

Additionally, on February 1, 2018, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in an individual qualified health plan with a plan enrollment start date of January 1, 2018. Your monthly premium was $474.96 to which your APTC of $231.00 was applied as of February 1, 2018.

On February 6, 2018, NYSOH issued a second notice of eligibility determination, based on the January 31, 2018 application, stating that you and your older child were eligible for up to $462.00 per month in APTC, effective February 1, 2018, and that your older child was eligible for cost-sharing reductions if he enrolled in a silver level qualified health plan, effective February 1, 2018. This notice stated that you did not qualify to select a health plan outside of the open enrollment period for 2018. However, your older child was eligible for a special enrollment period and directed to pick a health plan by April 1, 2018.

Also on February 6, 2018, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in an individual qualified health plan with a plan enrollment start date of January 1, 2018. Your monthly premium was $474.96 to which your APTC of $231.00 was applied as of February 1, 2018. This notice also stated that your older child was enrolled in an individual qualified health plan with a plan enrollment start date of February 1, 2018. His monthly premium was $474.96 to which his APTC of $231.00 was applied as of February 1, 2018.

On February 23, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar as you and your older child were ineligible to enroll in a parent and child qualified health plan.

On April 17, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You are seeking insurance for yourself and your older child.

2) The application you submitted on November 21, 2017 indicates that you expect to file your 2018 tax return as head of household and will claim your two children as dependents on that tax return. That application lists annual expected income of $41,000.00, consisting of $41,600.00 in wages you earn from your employment, less $600.00 in deductions for IRA contributions.

3) On January 30, 2018, you uploaded income documentation to your NYSOH account consisting of two biweekly paystubs; the first is for pay date December 29, 2017 for a gross pay amount of $1,666.58; the second is for pay date January 12, 2018 for a gross pay amount of $1,666.58.

4) On January 31, 2018, NYSOH verified the income documentation you submitted and recalculated your annual expected income to be $42,721.08, consisting of $43,331.08 in wages (four week's gross earnings of $3,333.16, divided by four for a weekly average of $833.29, multiplied by 52 weeks) less $600.00 in deductions for IRA contributions.

5) Also on January 31, 2018, NYSOH updated the income information in your application, and submitted an updated application for health insurance on your behalf. That application indicates that you expect to file your 2018 tax return as head of household and will claim your two children as dependents on that tax return.

6) The preliminary eligibility determination that was prepared on January 21, 2018 stated that your annual household income results in an FPL of 263.12% for you and an FPL of 209.26% for your older child.

7) As a result of the January 31, 2018 application, you and your older child were found eligible for APTC of up to $462.00 per month. Your older child was found eligible for cost-sharing reductions and you were found ineligible for cost-sharing reductions.

8) As your older child was found eligible for cost-sharing reductions and you were found ineligible for cost-sharing reductions, your older child was ineligible to remain enrolled in the same qualified health plan as you, and disenrolled from your parent and child qualified health plan as of January 31, 2018.

9) Your application states that you and your children reside in Monroe County.

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

Applicable Law and Regulations

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 $20,420.00 for a three-person household (82 Federal Register 8831).

For annual household income in the range of at least 200% but less than 250% of the 2017 FPL, the expected contribution is between 6.34% and 8.10% 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).

Cost-Sharing Reductions

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)).

Household Composition

For purposes of advance premium tax credit (APTC) and cost-sharing reductions (CSR), the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your older child were eligible to receive up to $462.00 per month in advance payments of the premium tax credit, and that you were ineligible for cost-sharing reductions, effective February 1, 2018.

The application that was submitted on January 31, 2018 listed an annual household income of $42,721.08.

For purposes of APTC, the household size of a taxpayer equals the number of individuals for whom the taxpayer is allowed a deduction including the taxpayer and any claimed dependents. The application you submitted on November 21, 2017 and the application that was submitted on your behalf on January 31, 2018 state that you expect to file your tax return for 2018 with a tax filing status of head of household. You will claim two dependents on that tax return. Therefore, you and your older child are in a three-person household.

The preliminary eligibility determination prepared on January 31, 2018 stated that your annual household income results in an FPL of 263.12%. As a result, you and your older child were found eligible for $462.00 in APTC and you were found ineligible for cost-sharing reductions.

However, an annual income of $42,721.08 is 209.21% of the 2017 FPL for a three-person household.

Therefore, NYSOH improperly determined that you were in a two-person household for the purpose of determining your eligibility on January 31, 2018.

Since the February 1, 2018 eligibility determination notice was based on an incorrect household size, it is RESCINDED.

Since your oldest child's disenrollment from your parent and child qualified health plan was based on the February 1, 2018 eligibility determination which relied on an improperly determined household size, the February 1, 2018 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you and your child into your parent and child qualified health plan as of February 1, 2018.

Your case is RETURNED to NYSOH to redetermine your and your oldest child's eligibility for financial assistance based on a household of three people residing in Monroe County with any annual expected income of $42,721.08 as of January 31, 2018.

Decision

The February 1, 2018 eligibility determination notice is RESCINDED.

The February 1, 2018 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you and your child into your parent and child qualified health plan as of February 1, 2018.

Your case is RETURNED to NYSOH to redetermine your and your oldest child's eligibility for financial assistance based on a household of three people residing in Monroe County with any annual expected income of $42,721.08 as of January 31, 2018.

Effective Date of this Decision: May 8, 2018

How this Decision Affects Your Eligibility

Your oldest child was improperly disenrolled from your parent and child qualified health plan as of January 31, 2018.

This is not a final determination of your and your oldest child's eligibility.

Your case is being sent back to NYSOH to redetermine your and your oldest child's eligibility using the correct household size of three people. NYSOH will send you a notice in the mail informing you of their determination.

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

Summary

The February 1, 2018 eligibility determination notice is RESCINDED.

The February 1, 2018 disenrollment notice is RESCINDED.

Your oldest child was improperly disenrolled from your parent and child qualified health plan as of January 31, 2018.

This is not a final determination of your and your oldest child's eligibility.

Your case is being sent back to NYSOH to redetermine your and your oldest child's eligibility using the correct household size of three people. NYSOH will send you a notice in the mail informing you of their determination.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

[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।

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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.

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