



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

Notice of Decision

Decision Date: April 22, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000006016

[REDACTED]

[REDACTED],

On April 5, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's January 5, 2016 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).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 22, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000006016

[REDACTED]

Issues

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

Did NY State of Health properly determine that you were eligible to receive up to \$5.00 per month in advance payments of the premium tax credit, effective February 1, 2016?

Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?

Procedural History

On December 10, 2015, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible to receive advance payments of the premium tax credit (APTC) in the amount of \$5.00 per month effective February 1, 2016.

Also on December 10, 2015 an enrollment confirmation notice was issued confirming your enrollment in a qualified health plan with a plan start date of January 1, 2016.

On January 5, 2016, NYSOH issued an eligibility redetermination notice again stating that you were eligible to receive advance payments of the premium tax credit (APTC) in the amount of \$5.00 per month effective February 1, 2016.

On January 6, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination as it related to the level of financial assistance you were determined eligible to receive.

On April 5, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you and your spouse both offered testimony. The record was developed during the hearing and kept open 15 days for you to provide supporting documentation in the form of income verification documents and termination of coverage from CareConnect. This documentation was received by NYSOH via a 7 page fax on April 6, 2016, and incorporated into the record as (Appellant's Exhibit 1).

Findings of Fact

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

- 1) You testified that you expect to file your 2016 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.
- 2) You are seeking insurance for yourself.
- 3) The application that was submitted on January 4, 2016, listed annual household income of \$46,400.00, consisting of earned income your spouse plans to receive in the amount of \$27,500.00, and Title II income your spouse will receive in the amount of \$21,600.00. The application also listed a deduction in the amount of \$2,700.00. You and your spouse testified that this amount was correct.
- 4) Your spouse testified that he receives \$450.00 per week. You provided evidence of this in the form of the supporting documentation you provided check # [REDACTED] dated 12/30/15, # [REDACTED] dated 1/8/16, # [REDACTED] dated 1/15/16, and #21556 dated 1/22/16, each for \$450.00 (Appellant's Exhibit 1, pg. 5-6).
- 5) You testified that your coverage through Care Connect was canceled on January 31, 2016 for nonpayment of premium. The record supports this in the form of the supporting evidence you provided (Appellant's Exhibit 1, pg. 2).
- 6) Your uploaded documentation shows that your spouse receives \$1,753.00 per month for 2016 in Social Security Title II (Appellant's Exhibit 1, pg. 4).
- 7) Your application states that you live in Queens 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 is generally available to a person who is eligible to enroll in a qualified health plan (QHP) 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 QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (see 45 CFR § 155.305(f), 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 2016 is set by federal law at 2.03% to 9.66% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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 2015 FPL, which is \$15,930.00 for a two -person household (80 Fed. Reg. 3236, 3237).

For annual household income in the range of at least 250% but less than 300 % of the 2015 FPL, the expected contribution is between 8.18% and 9.66% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP 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 QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Modified Adjusted Gross Income

The Marketplace 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 income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from time savings accounts, and deductions attributable to royalties (26 USC § 62(a)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to \$5.00 per month.

The application that was submitted on January 4, 2016, listed an annual household income of \$46,400.00 and the eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2016 income taxes as married filing jointly and will claim no dependents on that tax return.

You reside in Queens County, where the second lowest cost silver plan available for an individual through NYSOH costs \$368.26 per month.

An annual income of \$46,400.00 is 291.27% of the 2015 FPL for a two-person household. At 291.27% of the FPL, the expected contribution to the cost of the health insurance premium is 9.40% of income, or \$363.46 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 and individual in your county (\$368.26 per month) minus your expected contribution (\$363.46 per month), which equals \$4.80 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$5.00 per month in APTC.

The second issue is whether you were properly found ineligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of \$46,400.00 is 291.27% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

Since the January 5, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$5.00 per month in APTC, and ineligible for cost-sharing reductions, it is correct and is AFFIRMED.

During the hearing you testified, and the documentation you provided confirms, that your coverage through your qualified health plan was canceled on January 31, 2016 for nonpayment of premium. NYSOH Appeals Unit does not have the authority to review cancellations due to non-payment of premiums. You can contact your health plans customer service line to discuss any issues regarding payment due dates or late payments.

Decision

The January 5, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: April 22, 2016

How this Decision Affects Your Eligibility

You remain eligible for up to \$5.00 per month in APTC.

You are not eligible for cost sharing reductions.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

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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 U.S. Department of Health and Human Services. 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 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 January 5, 2016 eligibility determination notice is AFFIRMED.

You remain eligible for up to \$5.00 per month in APTC.

You are not eligible for cost-sharing reductions.

Legal Authority

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

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A Copy of this Decision Has Been Provided To:

