



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

Notice of Decision

Decision Date: October 28, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000008376



Dear [REDACTED],

On October 3, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's March 26, 2016 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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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Issues

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

Did New York State of Health properly determine that you were eligible to receive up to \$213.00 monthly of advance premium tax credits as of March 26, 2016?

Did New York State of Health properly determine that you were eligible for cost-sharing reductions as of March 26, 2016?

Procedural History

On December 15, 2015, you submitted a financial assistance application through New York State of Health (NYSOH).

On December 16, 2015, NYSOH issued a notice stating that you may be eligible for health insurance through NYSOH but more income information was needed to make a determination. The notice directed you to submit income documentation for your household by December 31, 2015, to confirm that the information you provided in your application was accurate.

On March 18, 2016, income documentation was uploaded to your NYSOH account ([REDACTED]).

On March 26, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for up to \$213.00 of advance premium tax credit and cost-sharing reductions, effective as of May 1, 2016.

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).

On March 28, 2016, you spoke to NYSOH Account Review Unit and requested an appeal insofar as the amount of financial assistance you were determined eligible to receive.

On October 3, 2016 you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing. The hearing record was left open until October 4, 2016 to allow you to submit your last four earnings statements from your employer.

On October 4, 2016, you faxed five-pages of documents to NYSOH Appeals Unit. These documents have been marked as "Appellant Exhibit A" and have been made part of the record. The record is now complete and closed.

Findings of Fact

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

1. According to your NYSOH account and testimony, you are applying for health insurance through NYSOH for yourself.
2. According to your NYSOH account and testimony, you plan on filing a 2016 federal income tax return with the tax status of single and will not be claiming any dependents on that tax return.
3. According to your December 15, 2015 application, you attested to an expected yearly income of \$15,000.00.
4. On December 16, 2015, NYSOH issued a notice stating that you may be eligible for health insurance through NYSOH but more income information was needed to make a determination ([REDACTED]).
5. You faxed four pay stubs from your employer, and those stubs were uploaded to your account on March 18, 2016. You were issued:
 - (a) \$320.00 in gross income on February 5, 2016 (Check # [REDACTED])
 - (b) \$560.00 in gross income on February 12, 2016 (Check # [REDACTED])
 - (c) \$560.00 in gross income on February 19, 2016 (Check # [REDACTED])
 - (d) \$560.00 in gross income on February 26, 2016 (Check # [REDACTED])
6. You testified that you are employed at [REDACTED] and that is your only source of income.
7. You testified that the February 2016 pay stubs don't accurately reflect your weekly income.

8. You testified that \$400.50 is an accurate reflection of your gross weekly income.
9. On October 4, 2016, you faxed your four most recent earnings statements from your employer. The Earnings Statements reflect that you were issued:
 - (a) \$400.50 on September 2, 2016, with a year-to-date (YTD) gross income of \$12,887.70;
 - (b) \$400.50 on September 16, 2016, with a YTD gross income of \$13,688.70;
 - (c) \$800.50 on September 23, 2016, with a YTD gross income of \$14,489.20
 - (d) \$400.50 on September 30, 2016, with a YTD gross income of \$15,132.70
(Appellant Exhibit A pgs. 2-5).
10. You indicated on your September 23, 2016 earnings statement that, “[t]his paycheck is not a true representation of my usual amount, it is a clerical error” (Appellant Exhibit A p. 3).
11. You currently reside in New York County, NY.

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

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)).

Income Verification Process

For all individuals whose income is needed to calculate the household’s eligibility, the NYSOH must request data that will allow the Marketplace to verify the household’s income (45 CFR §155.320(c)(1)(i)).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f)(1)).

Advance Premium Tax Credit:

The advance premium tax credit is 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 2015 federal poverty level; (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), 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 the 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).

For annual household income in the range of at least 200% but less than 250% of the 2015 FPL, the expected contribution is between 8.18% and 6.41% of the household income (see 26 CFR § 1.36B-3T(g)(1), (IRS Rev. Proc. 2014-62)).

In an analysis of APTC eligibility, the determination is based on the FPL "for the benefit year for which coverage is requested. (45 CFR § 155.305(f)(1)(i)). On the date of your application, that was the 2015 FPL, which is \$11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

Cost-Sharing Reductions:

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through the Marketplace, (2) meets the requirements to receive advanced premium tax credits, (3) is expected to have an annual household income that does not exceed 250 percent of the FPL for the plan year coverage is requested and (4) is enrolled in a silver-level QHP (45 CFR § 155.305(g)(1)).

Legal Analysis

The first issue is whether NYSOH properly determined you eligible for up to \$213.00 monthly of APTC.

On December 15, 2016, you attested to filing a 2016 federal income tax return, with the tax filing status of single, and did not expect to claim any dependent on that return. Furthermore you attested to an expected 2016 annual household income of \$15,000.00.

Based on your December 16, 2015 application, NYSOH issued a notice stating that your application was reviewed but more information was needed to make a determination. The notice directed you to submit income documentation to confirm that the information you provided in your application was accurate.

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income.

If NYSOH cannot verify the income information required to determine eligibility, they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

You submitted four pay stubs from your employer. Those stubs indicated that you were issued: \$320.00 in gross income on February 5, 2016; \$560.00 in gross income on February 12, 2016; \$560.00 in gross income on February 19, 2016, and \$560.00 in gross income on February 26, 2016.

Based on the income documentation you submitted (\$560.00 (+) \$560.00 (+) \$560.00 (+) \$320.00 (X) 13), NYSOH calculated your 2016 expected income to be \$26,000.00. The March 25, 2016 eligibility determination was based on the income documentation that you submitted to NYSOH.

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

An annual household income of \$26,000.00 equals 220.90% of the 2015 FPL for a one-person household. At 220.90% of the FPL, the expected contribution to the cost of the health insurance premium is 7.15% of income, or \$154.92 per month.

The maximum amount of APTC that can be awarded equals the cost of the second lowest cost silver plan in your county (\$368.26 per month) minus your expected contribution (\$154.92 per month), which equals \$213.34 per month. Therefore, NYSOH correctly computed your APTC to be \$213.00 per month.

The second issue is whether NYSOH properly determined you eligible for cost-sharing reductions.

Cost-sharing reductions are available to a person who has an annual household income no greater than 250% of the FPL. Since your annual household income is 220.90% of the FPL for purposes of APTC and cost-sharing reductions, you were correctly found eligible for cost-sharing reductions.

Since the March 26, 2016 eligibility determination properly stated that you are eligible for APTC of up to \$213.00 per month and eligible for cost-sharing reductions, it is correct and is AFFIRMED.

You testified that \$26,000.00 is not an accurate representation of your 2016 household income because you typically earn only \$400.50 per week. Furthermore, you submitted your most recent earnings statements to NYSOH Appeals Unit. The statements show that you were issued: \$400.50 on September 2, 2016, \$400.50 on September 9, 2016; \$400.50 on September 16, 2016; \$800.50 on September 23, 2016, and \$400.50 on September 30, 2016.

The record contains sufficient testimony and documentation to return your case to NYSOH to recalculate your eligibility for financial assistance. Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, living in New York County with an expected 2016 household income of (\$400.50 X 52) \$20,826.00.

Decision

The March 26, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on one-person household, living in New York County with an expected 2016 household income of \$20,826.00.

Effective Date of this Decision: October 28, 2016

How this Decision Affects Your Eligibility

You remain eligible to receive an advance premium tax credit of up to \$213.00 per month and eligible for cost-sharing reductions.

Your case is returned to NYSOH to recalculate your eligibility for financial assistance based on one-person household, living in New York County with an expected 2016 household income of \$20,826.00.

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.

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 after the date 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 date 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 March 26, 2016 eligibility determination notice is **AFFIRMED**.

Your case is **RETURNED** to NYSOH to recalculate your eligibility for financial assistance based on one-person household, living in New York County with an expected 2016 household income of \$20,826.00.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

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).

A Copy of this Decision Has Been Provided To:



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