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

Notice of Decision

Decision Date: October 31, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000008461

[redacted]

Dear [redacted]

On October 11, 2016, your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's March 30, 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: October 31, 2016

NY State of Health Account ID: [redacted]
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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 $213.00 per month in advance payments of the premium tax credit?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?

Procedural History

On January 11, 2016, NY State of Health (NYSOH) received your completed application for health insurance.

On January 12, 2016, NYSOH issued an eligibility determination notice based on the January 11, 2016 application, stating that you were eligible to enroll in the Essential Plan for a limited time. You were asked to provide income documentation in order to confirm your eligibility. This eligibility was based on a household income of $19,448.00.

On February 1, 2016 your authorized representative faxed in income documentation to NYSOH.

On February 11, 2016 your NYSOH account was updated to take into account the income documentation that NYSOH received.

On February 12, 2016, NYSOH issued an eligibility determination notice based on the information contained in the February 11, 2016 application, stating that you were newly eligible to purchase a qualified health plan at full cost. The notice also stated that you were not eligible for advance premium tax credits because you said you would not be filing a federal income tax return. You also were not eligible for the Essential Plan or Medicaid because your income was over the allowable limits for those programs. This eligibility was based on a household income of $26,000.00.

On March 28, 2016 your NYSOH account was updated to indicate that you expect to file a 2016 tax return.

On March 29, 2016, NYSOH issued an eligibility determination notice based on the information contained in the March 28, 2016 application, stating that you were newly eligible to receive advance premium tax credits of up to $213.00 per month and newly eligible to receive cost-sharing reductions. The notice also stated that you were not eligible for the Essential Plan because your income was over the allowable limits for that program. This eligibility was based on $26,000.00.

Also on March 29, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination as it related to the amount of financial assistance you were found eligible for. That day, you also requested Aid to Continue pending the outcome of your appeal.

On April 9, 2016 NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan because you were granted Aid to Continue until a decision is made on your appeal.

On April 11, 2016 your authorized representative submitted additional income documentation.

On October 11, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your authorized representative appeared and testified on your behalf. The record was developed during the hearing and remained open for 15 days to allow time for your authorized representative to submit additional income documentation. The documentation was received by fax on October 26, 2016 and was incorporated into the record as Appellant's Exhibit #1. The record is now closed.

Findings of Fact

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

1) Your authorized representative testified that you expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself.

3) The application that was submitted on March 28, 2016 listed annual household income of $26,000.00. Your authorized representative testified that this amount was correct at the time because you were earning $500.00 per week in employment.

4) Your authorized representative testified that at the end of March/April 2016 the amount of hours you worked per week changed. As a result, you were now making $350.00 per week and your expected household income decreased.

5) On April 11, 2016 your authorized representative sent in updated paystubs to NYSOH. Those paystubs show the following:

    a. On 3/19/2016 you received a gross pay of $500.00
    b. On 3/26/2016 you received a gross pay of $500.00, your year to date on this paystub was $6,500.00
    c. On 4/2/2016 you received a gross pay of $350.00
    d. On 4/9/2016 you received a gross pay of $350.00

6) On October 26, 2016 your authorized representative sent in updated paystubs to NYSOH Appeals Unit. Those paystubs show the following:

    a. On 4/16/2016 you received a gross pay of $350.00
    b. On 4/23/2016 you received a gross pay of $350.00
    c. On 4/30/2016 you received a gross pay of $350.00

7) Your authorized representative testified that you have continued working fewer hours and are still only receiving $350.00 per week.

8) Your application states that you live in Bronx 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

Advance payments of the premium tax credit (APTC) are 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 $11,770.00 for a one-person household (80 Federal Register 3236, 3237).

For annual household income in the range of at least 200% but less than 250% of the 2015 FPL, the expected contribution is between 6.41% and 8.18% 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).

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 (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)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to $213.00 per month.

The application that was submitted on March 28, 2016 listed an annual household income of $26,000.00 and the eligibility determination relied upon that information. Your authorized representative testified that this amount was correct at the time because you were earning $500.00 per week in employment.

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

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

An annual income of $26,000.00 is 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 approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county ($368.26 per month) minus your expected contribution ($154.92 per month), which equals $213.34 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $213.00 per month in APTC.

The second issue is whether you were properly found eligible 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 $26,000.00 is 220.90% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

Since the March 29, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $213.00 per month in APTC, and eligible for cost-sharing reductions, it is correct and is AFFIRMED.

However, your authorized representative testified that at the end of March/April 2016 the amount of hours you worked per week changed. As a result, you were now making $350.00 per week and your expected household income decreased. On April 11, 2016 and October 26, 2016 your authorized representative sent in updated paystubs to NYSOH which supports her testimony.

Therefore, your case is RETURNED to NYSOH to rerun your eligibility for financial assistance effective May 1, 2016 using a household size of one person, residing in Bronx County, with a household income of $20,500.00.

Decision

The March 29, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to rerun your eligibility for financial assistance effective May 1, 2016 using a household size of one person, residing in Bronx County, with a household income of $20,500.00.

Effective Date of this Decision: October 31, 2016

How this Decision Affects Your Eligibility

NYSOH properly determined you eligible for up to $213.00 per month in APTC and cost-sharing reductions based on the information contained in your March 28, 2016 application.

Your case is being sent back for a redetermination of your eligibility effective May 1, 2016 based on the income documentation you submitted in April and October 2016.

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 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 March 29, 2016 eligibility determination notice is AFFIRMED.

NYSOH properly determined you eligible for up to $213.00 per month in APTC and cost-sharing reductions based on the information contained in your March 28, 2016 application.

Your case is being sent back for a redetermination of your eligibility effective May 1, 2016 based on the income documentation you submitted in April and October 2016.

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]

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