



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

Notice of Decision

Decision Date: January 11, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000011182

[REDACTED]
[REDACTED],

On December 29, 2016, your spouse appeared on your behalf by telephone at a hearing on your appeal of NY State of Health's June 8, 2016 and August 2, 2016 eligibility determinations.

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: January 11, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000011182



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 enroll in a qualified health plan at full cost, effective July 1, 2016?

Did NY State of Health properly determine that you were eligible to enroll in a qualified health plan at full cost, effective September 1, 2016?

Procedural History

On June 8, 2016, NY State of Health (NYSOH) issued a notice of eligibility redetermination, based on your June 7, 2016 application, stating that you were eligible to purchase a qualified health plan (QHP) at full cost, effective July 1, 2016. The notice stated that you did not qualify to receive a tax credit to help pay for the cost of coverage because the income amount listed in your application, \$68,171.00, was over the allowable amount of \$63,720.00.

Also on June 8, 2016, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a bronze level QHP at a premium of \$296.73 monthly, effective, July 1, 2016.

On July 25, 2016 the income information in your account was updated and an application was submitted on your behalf.

On July 26, 2016, NYSOH issued a notice of eligibility redetermination, based on your July 25, 2016 application, stating that you were eligible to purchase a QHP at full cost, effective September 1, 2016. The notice stated that you did not

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).

qualify to receive a tax credit to help pay for the cost of coverage because the income amount listed in your application, \$114,925.92, was over the allowable amount of \$63,720.00.

On August 1, 2016, NYSOH received your updated application. That day, a preliminary eligibility determination was prepared stating that you were eligible to purchase a QHP at full cost, effective September 1, 2016.

Also on August 1, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not eligible for financial assistance to help pay for the cost of health coverage.

On August 2, 2016, NYSOH issued an eligibility determination notice based on the information contained in the August 1, 2016 application, stating that you were eligible to purchase a QHP at full cost, effective September 1, 2016. The notice stated that you did not qualify to receive a tax credit to help pay for the cost of coverage because the income amount listed in your application, \$99,544.06, was over the allowable amount of \$63,720.00.

On December 29, 2016, 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 spouse 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 only.
- 3) Your spouse testified that you both retired from your jobs in June 2016 and the only source of household income currently is the monthly Social Security Benefits you both receive.
- 4) The application that was submitted on June 7, 2016 listed annual household income of \$68,171.00, consisting of \$9,200.00 you earned from your employment and \$30,319.00 your spouse earned from his employment. The application also listed the amount you anticipated to receive in 2016 in Social Security Benefits as \$8,016.00 and the amount your spouse anticipated to receive in Social Security Benefits in 2016 as

- \$20,636.00. Your spouse testified that these amounts were correct at the time of the application.
- 5) Your spouse testified that after he retired in June 2016, he received a \$46,000.00 buy-out payment in July 2016 from his former employer.
 - 6) The application that was submitted on August 1, 2016 listed annual household income of \$99,544.06, consisting of \$10,319.08 you earned from your employment and \$76,589.98 your spouse earned from his employment, including the \$46,000.00 buy-out payment your spouse received in July 2016. The application also listed the amount you receive in monthly Social Security Benefits as \$654.00 and the amount your spouse receives in monthly Social Security Benefits as \$1,873.00. Your spouse testified that these amounts were correct at the time of the application.
 - 7) The record reflects that you enrolled in a full pay QHP beginning July 1, 2016 with a monthly premium of \$296.73
 - 8) Your spouse requested a review of the June 8, 2016 eligibility redetermination notice which found that you did not qualify for financial assistance to help pay for the cost of health insurance through NYSOH, because you have been struggling to pay the full premium amount without financial assistance since July 1, 2016.
 - 9) Your spouse testified that you were seeking an increased amount of APTC to help pay for the cost of your health coverage. He testified that you were not seeking eligibility for Medicaid.
 - 10) Your application states that you will not be taking any deductions on your 2016 tax return.
 - 11) Your application states that you live 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

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

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).

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 Federal Register 3236, 3237).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible to purchase a QHP at full cost, effective July 1, 2016.

The application that was submitted on June 7, 2016 listed an annual household income of \$68,717.00 and the eligibility determination relied upon that information. Your spouse testified that this income amount was correct at the time of the application and it consisted of earned income for you and your spouse as well as Social Security Benefits you both receive.

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 are seeking insurance for yourself only.

Your spouse testified that you were seeking an increased amount of APTC to help pay for the cost of your health coverage.

APTC are generally available to a person who is eligible to enroll in a QHP and (1) expects to have a household income between 138% and 400% of the applicable 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.

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. On the date of your application, that was the 2015 FPL, which is \$15,930.00 for a two-person household. The income amount included in your June 7, 2016 application, \$68,717.00, is 427.94% of the 2015 FPL for a two-person household. As APTC is only available to individuals who expect to have a household income less than 400% of the FPL, you were not eligible to receive APTC to help pay for the cost of health coverage.

Since the June 8, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible to purchase a QHP at full cost, it is correct and is AFFIRMED.

The second issue is whether NYSOH properly determined that you were eligible to purchase a QHP at full cost, effective September 1, 2016.

The application that was submitted on August 1, 2016 listed an annual household income of \$99,544.06 and the eligibility determination relied upon that information. Your spouse testified that this income amount was correct at the time of the application and it consisted of earned income for you and your spouse, including a \$46,000.00 buy-out payment your spouse received in July 2016 from his former employer, as well as Social Security Benefits you both receive.

As discussed above, APTC is only available to individuals who expect to have a household income less than 400% of the FPL. The income amount included in your August 1, 2016 application, \$99,544.06, is 624.88% of the 2015 FPL for a two-person household. Accordingly, pursuant to the information provided in your August 1, 2016 application, you were over the allowable income limit and, therefore you do not qualify for APTC to help pay for the cost of your health coverage through NYSOH.

Since the August 2, 2016 eligibility determination stated that, based on the information you provided, you were eligible to purchase a QHP at full cost, it is correct and is AFFIRMED.

Decision

The June 8, 2016 eligibility determination notice is AFFIRMED.

The August 2, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 11, 2017

How this Decision Affects Your Eligibility

You remain eligible to purchase a qualified health plan at full cost.

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

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).

- By mail at:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The June 8, 2016 eligibility determination notice is AFFIRMED.

The August 2, 2016 eligibility determination notice is AFFIRMED.

You remain eligible to purchase a qualified health plan at full cost.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

