



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

## Notice of Decision

Decision Date: July 5, 2017

NY State of Health Account ID [REDACTED]  
Appeal Identification Number: AP000000016456

[REDACTED]

Dear [REDACTED],

On June 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 3, 2017 eligibility determination.

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.

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## Decision

Decision Date: July 5, 2017

NY State of Health Account ID [REDACTED]  
Appeal Identification Number: AP000000016456

[REDACTED]

## Issues

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

Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to \$238.00 per month in advance payments of the premium tax credit (APTC), effective April 1, 2017?

Did NY State of Health properly determine that you were eligible for cost-sharing reductions?

## Procedural History

On March 2, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you were eligible to receive up to \$238.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective April 1, 2017.

Also on March 2, 2017, you spoke to NYSOH's Account Review Unit and appealed the amount of APTC for which you were determined eligible. You also requested Aid to Continue, pending the outcome of your appeal.

On March 3, 2017, NYSOH issued a notice of eligibility determination, based on the March 2, 2017 application, stating that you were eligible to receive up to \$238.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective April 1, 2017.

On March 16, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive APTC, effective January 1, 2017, because your request for Aid to Continue had been granted.

Also on March 16, 2017, NYSOH issued a notice of enrollment confirmation confirming your enrollment in a silver-level QHP, with the application of \$255.00 per month in APTC to your monthly premium, beginning January 1, 2017. This was pursuant to your request for Aid to Continue.

On June 15, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open through June 30, 2017, to allow you to submit corrected income documentation.

On June 21, 2017, NYSOH uploaded a letter that you mailed to NYSOH to the attention of the Hearing Officer. The record is now closed.

## **Findings of Fact**

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

- 1) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.
- 2) The application that was submitted on March 2, 2017 listed annual household income of \$26,400.00, consisting of \$4,800.00 in earned income, and \$21,600.00 you receive in Social Security Retirement benefits.
- 3) You testified that you are not sure, but you think your income may be a little higher than that, as the amount of your retirement benefits increased a little bit in 2017.
- 4) You testified that you receive \$1,851.00 per month in Social Security Retirement, and documentation that you mailed to NYSOH in May 2017 confirms this [REDACTED]
- 5) You testified that you also receive monthly income of \$450.00 for managing a company that is in "runoff" mode. You testified that this company belonged to [REDACTED], and that you are managing it while everything is being resolved and until the company is dissolved.
- 6) After the hearing, you supplied a letter, signed by you as [REDACTED] stating that you will receive \$450.00 per month for your work in 2017 for

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[REDACTED] This document is marked and entered into the record as "Appellant's [REDACTED]."

- 7) You testified that you had previously submitted income documentation, including a letter regarding the income you receive for managing [REDACTED], but that you had accidentally put an extra "0" in the amount, so that it incorrectly stated that you earn \$4,500.00 per month. You testified that this is not correct [REDACTED]
- 8) On May 23, 2017, NYSOH reran your eligibility based on this incorrect income documentation and recalculated your expected annual household income to be \$76,212.00. However, NYSOH did not issue a new eligibility determination based on this amount, as you were receiving Aid to Continue.
- 9) You testified that you do not have any other source of income.
- 10) You testified that you do have a health savings account, and that you expect your contributions will total about \$1,250.00 to that account for 2017.
- 11) Your application states that you live in [REDACTED].

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 (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 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

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 2016 FPL, which is \$11,880.00 for a one-person household (81 Federal Register 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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 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 APTC of up to \$238.00 per month, effective April 1, 2017.

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The application that was submitted on March 2, 2017 listed an annual household income of \$26,400.00 and the eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

You reside in [REDACTED], where the second lowest cost silver plan available for an individual through NYSOH costs \$396.98 per month.

An annual income of \$26,400.00 is 222.22% of the 2016 FPL for a one-person household. At 222.22% of the FPL, the expected contribution to the cost of the health insurance premium is 7.22% of income, or \$158.84 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 (\$396.98 per month) minus your expected contribution (\$158.84 per month), which equals \$238.14 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$238.00 per month in APTC, based on the information in your March 2, 2017 application.

However, during and after the hearing, you provided more exact income figures. You testified and provided documentation to show that your monthly gross income is a total of \$2,301.00, when your earned income and Social Security Retirement benefits are added together. You also testified that you expect to take a deduction for approximately \$1,250.00 in health savings account contributions.

Therefore, your expected annual income, after the deduction for your health savings account contribution, is \$26,362.00. Since the difference between your attested income on your March 2, 2017 application and this updated income figure is only \$38.00, it makes a negligible difference in the APTC calculation, and you would still be eligible for \$238.00 per month in APTC, based on the updated income information you provided during and after the hearing.

The second issue under review 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 \$26,400.00 is 222.22% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

Since the March 3, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$238.00 per month in APTC, and eligible for cost-sharing reductions it is correct and is **AFFIRMED**.

Additionally, your case is **RETURNED** to NYSOH to ensure that your application is updated to reflect an expected annual income of \$26,362.00, and **NOT**

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\$76,212.00 (the amount that NYSOH calculated based on the incorrect income documentation that was previously submitted).

## **Decision**

The March 3, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH ensure that your eligibility is based on income of \$26,362.00, and NOT the incorrect \$76,212.00 figure that was entered into your application by NYSOH on May 23, 2017.

**Effective Date of this Decision:** July 5, 2017

## **How this Decision Affects Your Eligibility**

You remain eligible for up to \$238.00 per month in APTC.

You are eligible for cost-sharing reductions.

The income in your application will be corrected to reflect an expected annual income of \$26,362.00.

## **If You Disagree with this Decision (Appeal Rights)**

This 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:

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 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 March 3, 2017 eligibility determination notice is **AFFIRMED**.

Your case is **RETURNED** to NYSOH ensure that your eligibility is based on income of \$26,362.00, and **NOT** the \$76,212.00 figure that was entered into your application by NYSOH on May 23, 2017.

You remain eligible for up to \$238.00 per month in APTC.

You are eligible for cost-sharing reductions.

The income in your application will be corrected to reflect an expected annual income of \$26,362.00.

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## **Legal Authority**

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**A Copy of this Decision Has Been Provided To:**



## 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 مجاناً.

### বাংলা (Bengali)

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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।

### **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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ kasa a woka no ase ama wo kwa a wontua hwee.

### **(Urdu) اردو**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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