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

Notice of Decision

Decision Date: August 03, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000016469

Dear

On June 22, 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.

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

Decision

Decision Date: August 03, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016469

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine you were eligible to receive up to $222.00 per month in advance payments of the premium tax credit, effective April 1, 2017?

Procedural History

On March 2, 2017, NYSOH received your updated application for financial assistance. That day, a preliminary eligibility determination was prepared stating you were eligible to receive up to $222.00 in monthly advance payments of the premium tax credit (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 determination insofar as you were not eligible for the Essential Plan.

On March 3, 2017, NYSOH issued a notice of eligibility determination, based on the March 2, 2017 application, stating you were eligible to receive up to $222.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective April 1, 2017. The notice indicated you were not eligible for the Essential Plan, because your annual income was over the allowable income limit for that program.

On June 22, 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 to allow you to submit supporting documents.

On July 5, 2017, NYSOH Appeals Unit received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1. The record closed thereafter.

Findings of Fact

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

1) According to your account, you were determined eligible for the Essential Plan based on an online application submitted on January 21, 2017. That application indicated you earned $16.00 an hour and worked 40 hours per week; however, the application also indicated that your annual income was the same as the last tax year, $26,408.00.

2) According to your account, NYSOH determined you eligible for the Essential Plan, effective March 1, 2016, based on the annual income amount of $26,408.00.

3) You testified the annual income amount of $26,408.00 was not accurate of your income in 2016. You testified you are not sure where that number came from.

4) According to your account, you were disenrolled from your Essential Plan on February 28, 2017, because you did not update your account and renew your coverage by February 15, 2017.

5) On March 2, 2017, you contacted NYSOH and an updated application was submitted on your behalf. That application indicated you earned $16.00 an hour and worked 40 hours a week and listed an annual income of $33,280.00.

6) The application indicated you will file your 2017 tax return with a tax filing status of head of household and you will claim one dependent on that tax return. You testified this information was accurate.

7) Based on the annual income amount of $33,280.00 listed in the March 2, 2017 application, NYSOH determined you were eligible to receive up to $222.000 in APTC, effective April 1, 2017.

8) You appealed that determination insofar as you were not eligible for the Essential Plan.

9) You testified that you make $16.00 an hour and you work 40 hours a week, but that some weeks you earn less if you have to take time off, which you are not paid for.

10) You testified you expect to earn the same amount of income in 2017 as you did in 2016.

11) You submitted a copy of a form 1040A from your 2016 tax return indicating your adjusted gross income for 2016 was $31,060.00.

12) According to your account, you were granted Aid to Continue on March 7, 2017 and you were enrolled in your previous Essential Plan, effective March 1, 2017, pending the outcome of this decision.

13) You testified, and your March 2, 2017 application indicates, you will not be taking any deductions on your 2017 tax return.

14) 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

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 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 in effect on 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 $16,020.00 for a two-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).

<u>Cost-Sharing Reductions</u>

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)).

<u>Modified Adjusted Gross Income</u>

NYSOH 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 federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Legal Analysis

The issue is whether NYSOH properly determined you were eligible for an APTC of up to $222.00 per month, effective April 1, 2017.

The application that was submitted on March 2, 2017 indicated you earn $16.00 an hour and you work 40 hours for an annual income of $33,280.00. Based on that information, NYSOH determined you eligible to receive up to $222.000 in APTC, effective April 1, 2017. You appealed that determination insofar as you were not eligible for the Essential Plan.

You testified that you do not understanding why you are no longer eligible for the Essential Plan, because you provided the same income information in 2016 as you did on the March 2, 2017 application, and you were found eligible for the Essential Plan in 2016 based on that information. However, according to your account, although your January 21, 2016 application indicated you earned $16.00 an hour and worked 40 hours per week, it also indicated that your anticipated income for 2016 was the same as the previous tax year, $26,408.00. Your account confirms, NYSOH determined your eligibility for the Essential Plan in 2016 based on the annual income amount of $26,408.00 as indicated in your application. You testified that $26,408.00 was not your income for 2016, because you earned more than that.

It is noted that the January 22, 2016 eligibility determination finding you eligible for the Essential Plan is not properly under review as there was no timely appeal on that issue. Thus, the issue under appeal to be resolved with this decision is your eligibility based on your March 2, 2017 application.

Although you testified that the income information in your March 2, 2017 application was accurate, in that you earn $16.00 an hour and work 40 hours per week, you also testified that some weeks you earn less if you have to take time off, which you are not paid for. You testified you expect to earn the same amount of income in 2017 as you did in 2016, because you work at the same job and earn the same hourly wage and work the same number of hours.

You submitted a copy of a Form 1040A from your 2016 tax return indicating your adjusted gross income for 2016 was $31,060.00. It is concluded that this is a

more accurate representation of your expected income for 2017. This is based on your credible testimony that your income in 2017 is expected to be about the same as your income in 2016 (as evidenced by your 2016 tax return) and that the annual income amount of $33,280.00 listed in the March 2, 2017 application did not account for any unpaid time off you may take throughout the year.

The Appeals Unit find that the record now contains more accurate income information than existed at the time of the March 3, 2017 eligibility determination.

Accordingly, the March 3, 2017 eligibility determination stating you were eligible to receive up to $222.00 in APTC, effective April 1, 2017 is RESCINDED as it was based on income information no longer supported by the record.

Your case is RETURNED to NYSOH to redetermine your eligibility for health insurance, as of the date of your March 2, 2017 application, utilizing an annual household income of $31,060.00 and a two-person household in [redacted] [redacted], based on the now developed record.

Decision

The March 3, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for health insurance, as of the date of your March 2, 2017 application, utilizing an annual household income of $31,060.00 and a two-person household, based on the now developed record.

Effective Date of this Decision: August 03, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility based on the updated annual income amount of $31,060.00.

You will receive an updated eligibility determination notice from NYSOH.

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:

- 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 RESCINDED.

This is not a final determination of your eligibility.

Your case is being RETURNED back to NYSOH to redetermine your eligibility based on the updated annual income amount of $31,060.00.

You will receive an updated eligibility determination notice from NYSOH.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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).

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 مجانًا.

বাংলা (Bengali)

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।

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).

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 महत्त्वपूर्ण 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 yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ 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 کرم1-855-355-5777 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 דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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