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

Notice of Decision

Decision Date: July 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017501

[redacted]

Dear [redacted],

On July 13, 2017 you appeared by telephone at a hearing on your appeal of NY State of Health's March 21, 2017 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: July 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017501

[redacted]

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 and your [redacted] were eligible to receive up to $306.00 per month in advance payments of the premium tax credit, effective May 1, 2017?
>
> Did NY State of Health properly determine that you and your [redacted] were ineligible for cost-sharing reductions?

Procedural History

On November 13, 2016, NY State of Health (NYSOH) issued a renewal notice stating that you, your [redacted], and your [redacted] were eligible to receive up to $306.17 per month in advance payments of the premium tax credit (APTC), effective January 1, 2017. This was based on the income listed in the application you submitted on October 24, 2016.

On December 16, 2016, NYSOH issued a notice of enrollment stating that you, your [redacted], and your [redacted] were enrolled in your qualified health plan with a premium of $907.78 per month after your APTC of $306.17 was applied. The notice also stated that your APTC would be applied to your monthly premium, effective January 1, 2017.

On February 16, 2017, you updated your household's application for financial assistance. Specifically, you indicated that your [redacted] was no longer seeking coverage through NYSOH.

On February 18, 2017, NYSOH issued a notice of eligibility determination stating that you and your [redacted] were eligible to receive up to $306.00 per month in APTC for a limited time, effective April 1, 2017. This notice further stated that you needed to provide proof of your household's income by May 18, 2017 in order to confirm your and your [redacted] eligibility for financial assistance with health insurance.

Also on February 18, 2017, NYSOH issued a notice of enrollment stating that you and your [redacted] were enrolled in your qualified health plan with a premium of $907.95 per month after your APTC of $306.00 was applied. The notice also stated that your APTC would be applied to your monthly premium, effective April 1, 2017.

On February 22, 2017, you updated your household's application for financial assistance.

On February 23, 2017, NYSOH issued a notice of eligibility determination stating that you and your [redacted] were eligible to receive up to $306.00 per month in APTC for a limited time, effective April 1, 2017. This notice further stated that you needed to provide proof of your household's income by May 18, 2017 in order to confirm your and your [redacted] eligibility for financial assistance with health insurance.

On March 10, 2017, income documentation was uploaded to your NYSOH account.

On March 20, 2017, NYSOH reviewed the income documentation you submitted, determined that this was sufficient proof of your household's income, and submitted an application on your household's behalf.

On March 21, 2017, NYSOH issued a notice of eligibility determination stating that you and your [redacted] were eligible to receive up to $306.00 per month in APTC, effective May 1, 2017. You and your [redacted] were not eligible for cost-sharing reductions because your household income was over the allowable income limit for that program.

On March 30, 2017, you spoke to NYSOH's Account Review Unit and appealed this determination insofar as you and your [redacted] were not found eligible for additional financial assistance.

On June 5, 2017, you updated your household's application for financial assistance. Specifically, you indicated that you would no longer be claiming your [redacted] as a dependent and adjusted your household's annual expected income.

On June 6, 2017, NYSOH issued a notice of eligibility determination stating that you and your [redacted] were eligible to receive up $402.00 per month in APTC for a limited time, effective July 1, 2017. This notice further stated that you needed to provide proof of your household's income by September 3, 2017 in order to confirm your and your [redacted] eligibility for financial assistance with health insurance.

Also on June 6, 2017, NYSOH issued a notice of enrollment stating that you and your [redacted] were enrolled in your qualified health plan with a premium of $811.95 per month after your APTC of $402.00.00 was applied. The notice also stated that your APTC would be applied to your monthly premium, effective July 1, 2017.

On July 13, 2017, 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 testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim one dependent on that tax return.

2) You are seeking insurance for yourself and your [redacted].

3) The application that was submitted on March 20, 2017 listed annual household income of $64,800.00, consisting of $36,000.00 your spouse earns from [redacted] employment and $28,800.00 your spouse receives in Social Security benefits. You testified that this amount was incorrect and you believe your household's income was incorrectly put into the system.

4) The application that was submitted on March 20, 2017 indicated that you expected to file your 2017 taxes with a tax filing status of married filing jointly and would claim two dependents on that tax return.

5) On June 5, 2017 you updated your account to reflect that you were no longer claiming your [redacted] as a dependent on your 2017 tax return.

6) You testified that neither you nor your [redacted] have any income.

7) You testified that your annual household income is currently $52,595.00 consisting of $28,800.00 your spouse receives in Social Security benefits and $23,795.00 your spouse expects to earn in wages in 2017.

8) You testified that your spouse's wages vary from pay period to pay period because [redacted] pay is based on commission.

9) On March 6, 2017 you faxed income documentation to NYSOH. This documentation consisted of a letter dated March 3, 2017 signed by yourself and your spouse stating that you and your [redacted] do not have any income and that your spouse is the sole provider for your household. This submission also included your and your spouse's 2016 tax return which indicated wages of $38,461.00, Social Security benefits of $30,215.00 with $14,134.00 as the taxable portion of Social Security benefits, for an adjusted gross income of $52,595.00.

10) Your application states, and you confirmed, that you will not be taking any deductions on your 2017 tax return.

11) Your application states, and you testified, that you live in [redacted].

12) During the hearing, you gave permission for the Hearing Officer to listen to phone calls between yourself and NYSOH.

13) On October 24, 2016, you placed a call to NYSOH. A review of the recording of that phone call reveals that you authorized your spouse as your representative at that time. Your spouse updated your household's application for financial assistance. Your spouse advised that [redacted] income consisted of $36,000.00 in wages and $2,400.00 per month in Social Security benefits. Your spouse stated that no other members of your household had any income. The NYSOH representative confirmed with your spouse that your household's annual expected income was $64,800.00.

14) On February 16, 2017, you placed a call to NYSOH. A review of the recording of that phone call reveals that you were requesting to remove your [redacted] from your qualified health plan as your [redacted] was found eligible for Medicare. You indicated that there were no other changes to report at that time. The NYSOH representative updated your household's application per your request to indicate that your [redacted] no longer needed health insurance through NYSOH. There was a technical issue with your application and the NYSOH representative advised you to call back in a few days to confirm your eligibility.

15) On February 22, 2017, you placed a call to NYSOH. A review of the recording of that phone call reveals that you were calling to confirm that your [redacted] had been removed from your qualified health plan and to find out what your new premium would be. The NYSOH representative advised you that your application would need to be resubmitted. You

advised the NYSOH representative that the only change to your household was that your [redacted] would have coverage through Medicare as of March 1, 2017 and would no longer require coverage through NYSOH.

16) You placed additional phone calls to NYSOH on March 2, 2017, March 4, 2017, and March 6, 2017. A review of the recordings of those phone calls reveals that at no time during those phone calls did you advise the NYSOH representatives that the income listed for your household was incorrect.

17) On March 30, 2017, you placed a call to NYSOH. A review of the recording of that phone call reveals that you authorized your spouse to act as your representative. Your spouse advised the NYSOH representative that when [redacted] updated application, [redacted] overstated [redacted] income. You requested during that phone call that your eligibility be based on your income tax return which indicated income of $52,000.00.

18) You testified that you are seeking to have additional APTC applied to your and your [redacted] premiums as of January 1, 2017.

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 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 $24,300.00 for a four-person household (81 Federal Register 4036).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% 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 (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)).

Modified Adjusted Gross Income

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)).

Verification of Eligibility for Advance Payments of the Premium Tax Credit

APTC are generally 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 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 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)).

An applicant is required to attest to their household's projected annual income for purposes of determining their eligibility for APTC (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant in order to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective as of the first day of the month following the date of the notice (45 § 155.310(f), 45 CFR § 155.330(e), (f)(1)(i)).

Legal Analysis

The first issue is whether NYSOH properly determined that you and your [redacted] were eligible for an APTC of up to $306.00 per month, effective May 1, 2017.

On October 24, 2016, your spouse, serving as your authorized representative, advised NYSOH that your household annual expected income was $64,800.00

consisting of $36,000.00 in your spouse's wages and $28,800.00 in your spouse's Social Security benefits.

On March 6, 2017, you faxed income documentation to NYSOH. This income documentation included a letter that indicates that neither you nor your [redacted] have any income and that your spouse is the sole source of support for yourself and your [redacted]. This income documentation also included your and your spouse's 2016 tax return which listed wages of $38,461.00, Social Security benefits of $30,215.00 of which $14,134.00 is the taxable portion of Social Security benefits, for an adjusted gross income of $52,595.00.

During the phone call on March 30, 2017 you represented that your household's annual income was $52,000.00, and that this was based on your 2016 tax return which you had submitted to NYSOH.

NYSOH bases its eligibility determinations on modified adjusted gross income. Modified adjusted gross income includes Social Security benefits that were excluded from gross income. Therefore, based on your 2016 tax return, your household's modified adjusted gross income was $68,676.00.

On March 20, 2017, NYSOH reviewed the income documentation you submitted on March 6, 2017 and determined that this documentation was sufficient to verify the $64,800.00 annual expected household income as reported by your spouse.

The application that was submitted on March 20, 2017 listed an annual household income of $64,800.00 and the eligibility determination relied upon that information.

At the time of the March 20, 2017 application, your account indicated that you expected to file your 2017 tax return as married filing jointly and would claim two dependents, therefore, at the time of the March 20, 2017 application, you and your [redacted] were in a four-person household.

You reside in [redacted], where the second lowest cost silver plan available for an individual and one dependent through NYSOH costs $775.97 per month.

An annual income of $64,800.00 is 266.67% of the 2016 FPL for a four-person household. At 266.67% of the FPL, the expected contribution to the cost of the health insurance premium is 8.70% of income, or $469.98 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 and one dependent in your county ($775.97 per month) minus your expected contribution ($469.98 per month), which equals $305.99 per month. Therefore,

rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $306.00 per month in APTC.

The second issue is whether you and your son were properly found ineligible 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 $64,800.00 is 266.67% of the applicable FPL, NYSOH correctly found you and your [redacted] to be ineligible for cost sharing reductions.

Since the March 21, 2017 eligibility determination notice properly stated that, based on the information you provided, you and your [redacted] were eligible for up to $306.00 per month in APTC, and ineligible for cost-sharing reductions, it is correct and is AFFIRMED.

During the hearing, you testified that your annual expected household income is currently $52,595.00. Your household's application was updated with this information on June 4, 2017 and your and your [redacted] eligibility was redetermined accordingly. As such, the NYSOH Appeals Unit declines to return your case for a redetermination based on this information.

Decision

The March 21, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: July 21, 2017

How this Decision Affects Your Eligibility

You and your [redacted] were correctly determined eligible for up to $306.00 in APTC.

You and your [redacted] are ineligible for cost-sharing reductions.

This decision does not affect any subsequent eligibility determinations.

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 21, 2017 eligibility determination notice is AFFIRMED.

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).

You and your [redacted] were correctly determined eligible for up to $306.00 in APTC.

You and your [redacted] are ineligible for cost-sharing reductions.

This decision does not affect any subsequent eligibility determinations.

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]

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.

□□□□□ (Bengali)

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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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.

اردو (Urdu)

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)

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).

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.

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).