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

Notice of Decision

Decision Date: September 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018521

Dear [redacted],

On August 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 18, 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: September 6, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000018521

Issues

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

> Was your appeal of NY State of Health's (NYSOH) February 18, 2017 eligibility determination notice timely?
>
> Did NYSOH properly determine that you, your spouse, and your child were eligible to receive up to $752.00 per month in advance payments of the premium tax credit, effective March 1, 2017?
>
> Did NYSOH properly determine that you, your spouse, and your child were not eligible for cost-sharing reductions?

Procedural History

On December 29, 2016, you submitted an application for financial assistance.

On December 30, 2016, NYSOH issued a notice of eligibility determination, stating that you, your spouse, and your child were eligible to receive up to $1,012.00 in advance payments of the premium tax credit and eligible to receive cost-sharing reductions if you enrolled in a silver-level qualified health plan, for a limited time, effective February 1, 2017. The notice directed you to submit proof of income by March 29, 2017.

Also on December 30, 2016, NYSOH issued an enrollment confirmation notice stating that you, your spouse, and your child were enrolled in a qualified health plan, effective February 1, 2017.

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On February 8, 2017, you submitted income documentation.

On February 17, 2017, the income information in your NYSOH account was updated to reflect the documentation that you had submitted and an application was submitted on your behalf.

On February 18, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your child were eligible to receive up to $752.00 in APTC, effective April 1, 2017. That notice also stated that you were not eligible for cost-sharing reductions, the Essential Plan, or Medicaid because your income was over the allowable income limits for those programs.

On February 19, 2017, NYSOH issued a notice of enrollment confirmation notice, stating that you, your spouse, and your child were enrolled in a qualified health plan with a start date of February 1, 2017. The notice further stated that your advance premium tax credit of $752.00 would be applied to your monthly premium starting March 1, 2017.

On March 13, 2017, you submitted additional income documentation.

On March 16, 2017, you submitted an updated application for financial assistance.

On March 17, 2017, NYSOH issued an eligibility determination stating that you, your spouse, and your child were eligible to receive up to $1,031.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective May 1, 2017.

Also on March 17, 2017, NYSOH issued an enrollment confirmation notice, stating that you, your spouse, and your child were enrolled in a qualified health plan with a start date of February 1, 2017. The notice further stated that your premium amount was $995.08 per month, and that your advance premium tax credit of $995.08 would be applied to your monthly premium starting April 1, 2017.

On March 22, 2017, the income information in your NYSOH account was updated to reflect the documentation that you had submitted and an application was submitted on your behalf.

On March 23, 2017, NYSOH issued an eligibility determination stating that if you qualified for a special enrollment period, you, your spouse, and your child were eligible to receive up to $1,034.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective May 1, 2017.

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).

Also on March 23, 2017, NYSOH issued an enrollment confirmation notice, stating that you, your spouse, and your child were enrolled in a qualified health plan with a start date of February 1, 2017. The notice further stated that your premium amount was $995.08 per month, and that your advance premium tax credit of $995.08 would be applied to your monthly premium starting April 1, 2017.

On May 1, 2017, you spoke to NYSOH's Account Review Unit and appealed the reduction of your APTC for the month of March 2017.

On August 9, 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, your spouse, and your child.

3) The application that was submitted on February 17, 2017 listed an annual household income of $62,326.16, consisting of $20,748.00 you earn from your employment and $41,578.16 your spouse earns from her employment. You testified that this is not correct.

4) On February 8, 2017, you uploaded two of your spouse's paychecks:
    a. dated January 19, 2017, covering the period from December 17, 2016 to December 30, 2016 for a gross pay amount of $1,643.64
    b. dated January 20, 2017, covering the period from December 31, 2016 to January 13, 2017 for a gross pay amount of $1,554.68

5) You testified that your expected annual gross income is between $15,000.00 and $20,000.00.

6) On March 13, 2017, you submitted a letter from your spouse's employer stating that her annual salary is between $18,000.00 and $20,000.00.

7) Your child does not have any income.

8) The record reflects that a call was made to NYSOH on February 28, 2017 regarding informal dispute resolution and income documentation.

9) The record reflects that a complaint was opened on April 28, 2017 regarding the calculation of your household's income.

10) Your application states that you will not be taking any deductions on your 2017 tax return. You testified that you will be taking a student loan interest deduction.

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

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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 $20,160.00 for a three-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 300% but less than 400% of the 2016 FPL, the expected contribution is 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)).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's February 18, 2017 eligibility determination notice was timely.

On May 1, 2017, you filed a formal appeal on the amount of APTC you, your spouse, and your child were eligible for as stated in the February 18, 2017 eligibility determination notice.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of the notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your eligibility as stated in the February 18, 2017 eligibility determination notice, an appeal should have been filed by April 19, 2017.

Although your appeal was untimely on its face, the record reflects that a call was placed to NYSOH on February 28, 2017 regarding your, your spouse's, and your child's eligibility.

As you originally contacted NYSOH within sixty (60) days of the February 18, 2017 notice and spoke with a representative about your eligibility, your failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal.

The second issue is whether NYSOH properly determined that you, your spouse, and your child were eligible for an APTC of up to $752.00 per month, effective March 1, 2017.

The application that was submitted on February 17, 2017 listed an annual household income of $62,326.16 and the eligibility determination relied upon that information. Although you testified that this amount was not correct, a reasonable calculation of your spouse's paystubs that you submitted ($1,643.64 + $1,554.68 = $3,198.32 / 4 weeks x 52 weeks) yields an annual expected gross income of $41,578.16. On March 13, 2017, you submitted a letter from your spouse's employer stating that her actual annual salary is between $18,000.00 and $20,000.00. Since this information was not provided to NYSOH in your initial submission of income documentation on February 8, 2017, NYSOH properly relied upon the paystubs you submitted for your spouse showing an income of $41,578.16 and your attested annual expected gross income of $20,748.00, resulting in an annual household income of $62,326.16.

You, your spouse, and your child are in a three-person household. You expect to file your 2017 income taxes as married filing jointly and will claim one dependent on that tax return.

You reside in [redacted], where the second lowest cost silver plan available for a couple and one dependent through NYSOH costs $1,254.90 per month.

An annual income of $62,326.16 is 309.16% of the 2016 FPL for a three-person household. At 309.16% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or $503.28 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 a couple and one dependent in your county ($1,254.90 per month) minus your expected contribution ($503.28 per month), which equals $751.62 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you, your spouse, and your child to be eligible for up to $752.00 per month in APTC.

The third issue is whether you, your spouse, and your child were properly found not 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 $62,326.16 is 309.16% of the applicable FPL, NYSOH correctly found you to be not eligible for cost sharing reductions.

Since the February 18, 2017 eligibility determination properly stated that, based on the information available at the time, you, your spouse, and your child were eligible for up to $752.00 per month in APTC, and not eligible for cost-sharing reductions, it is correct and is AFFIRMED.

Decision

The February 18, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 6, 2017

How this Decision Affects Your Eligibility

You, your spouse, and your child were properly determined eligible for up to $752.00 in APTC based on the documentation you submitted.

You, your spouse, and your child were properly determined not eligible for cost-sharing reductions.

This decision does not affect 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 February 18, 2017 eligibility determination notice is AFFIRMED.

You, your spouse, and your child were properly determined eligible for up to $752.00 in APTC.

You, your spouse, and your child were properly determined not eligible for cost-sharing reductions.

This Decision does not affect subsequent eligibility determinations.

Legal Authority

We are sending you this notice in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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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)

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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 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 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 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).

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