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

Notice of Decision

Decision Date: September 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019753

[redacted]

On September 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 3, 2017 eligibility determination notice and the June 3, 2017 enrollment confirmation 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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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).

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

Decision

Decision Date: September 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019753

[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, your spouse, and your daughter were eligible to receive up to $947.00 per month in advance payments of the premium tax credit, effective July 1, 2017?
>
> Did NY State of Health properly determine that you, your spouse, and your daughter were ineligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that your family's plan premium is $1,138.83 per month?

Procedural History

On January 20, 2017, you submitted an application for financial assistance for your household.

On January 21, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination, based on the January 20, 2017 application, stating that you, your spouse, your son, and your daughter were eligible to receive up to $821.00 per month in advance payments of the premium tax credit (APTC) for a limited time, effective March 1, 2017. This notice directed you to submit proof of your household's income by April 13, 2017 in order to confirm your, your spouse's, and your son's eligibility for financial assistance and by April 20, 2017 in order to confirm your daughter's eligibility for financial assistance.

On January 21, 2017, NYSOH issued a notice of enrollment confirmation stating that you, your spouse, your son, and your daughter were enrolled in a Fidelis Care bronze level family plan with a premium of $1,138.83 and a monthly premium cost of $317.83 per month after your APTC was applied, effective March 1, 2017.

No income documentation was submitted by April 13, 2017.

On April 19, 2017, NYSOH redetermined your household's eligibility for financial assistance.

On April 21, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your son were eligible to purchase a qualified health plan at full cost through NYSOH, effective June 1, 2017, and that your daughter was eligible for $0.00 in APTC for a limited time, effective June 1, 2017. This notice also directed you to submit documentation of your household's income by April 20, 2017 in order to confirm your daughter's eligibility for financial assistance.

Also on April 21, 2017, NYSOH issued a disenrollment notice stating you're your daughter's coverage in her qualified health plan would end on May 31, 2017. This was because she was no longer eligible to enroll in her current plan.

Additionally, on April 21, 2017, NYSOH issued a notice of enrollment confirmation stating that you, your spouse, and your son were enrolled in a Fidelis Care bronze level family plan with a premium of $1,138.83.

No income documentation was submitted by April 20, 2017.

On April 26, 2017, NYSOH redetermined your household's eligibility for financial assistance.

On April 27, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, your son, and your daughter were eligible to purchase a qualified health plan at full cost through NYSOH, effective June 1, 2017.

On May 1, 2017, you updated your household's application for financial assistance.

On May 2, 2017, NYSOH issued a notice of eligibility determination, based on the May 1, 2017 application, stating that you, your spouse, your son, and your daughter were eligible to receive up to $821.00 per month in APTC for a limited time, effective June 1, 2017. This notice directed you to submit proof of your household's income by July 30, 2017 in order to confirm your household's eligibility for financial assistance.

Also on May 2, 2017, NYSOH issued a notice of enrollment confirmation stating that you, your spouse, your son, and your daughter were enrolled in a Fidelis Care bronze level family plan, effective March 1, 2017, with a premium of $1,138.83 and a monthly premium cost of $317.83 per month after your APTC of $821.00 per month was applied as of June 1, 2017.

On June 2, 2017, you updated your household's application for financial assistance. Specifically, you removed your son from your household and updated your household's annual expected income.

On June 3, 2017, NYSOH issued a notice of eligibility determination, based on the June 3, 2017 application, stating that you, your spouse, and your daughter were eligible for up to $947.00 per month in APTC, effective July 1, 2017.

Also on June 3, 2017, NYSOH issued a disenrollment notice stating that your son's coverage in his qualified health plan would end on June 30, 2017. This was because he was no longer eligible to enroll in coverage through NYSOH.

Additionally, on June 3, 2017, NYSOH issued a notice of enrollment confirmation stating that you, your spouse, and your daughter were enrolled in a Fidelis Care bronze level family plan, effective March 1, 2017, with a premium of $1,138.83 and a monthly cost of $191.83 per month after your APTC of $947.00 per month was applied as of July 1, 2017.

On June 14, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as your plan premium did not decrease when your household changed from a four-person household to a three-person household.

On September 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your spouse was present and provided testimony. 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) Your spouse testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly and that you will one dependent, your daughter, on that tax return.

2) You are seeking insurance for yourself, your spouse, and your daughter.

3) The application that was submitted on June 2, 2017 listed annual household income of $77,999.99, consisting of $77,999.99 your spouse

earns from your employment. Your spouse testified that this amount is correct.

4) Your spouse testified that you do not have any income.

5) Your spouse testified that you are not sure if your daughter will be filing a tax return for 2017, however, she has not filed a tax return in previous years.

6) Your spouse testified that your daughter began working a part time job in late August 2017 or early September 2017 and that her expected annual income is currently $2,000.00.

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

8) Your application states, and your spouse confirmed, that you live in [redacted].

9) Your NYSOH account reflects that your son was removed from your account on June 2, 2017.

10) You and your spouse testified that you are seeking to have your family plan premium reduced as of July 1, 2017. Your spouse explained that you are not seeking additional tax credits, rather, you are seeking for the plan premium of your Fidelis Care bronze family plan to be reduced as the plan now only covers three people rather than four. You and your spouse testified that you are not seeking to switch to a different plan with a lower premium, you want to remain in the same plan and have the premium reduced on a pro rata basis.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Appealable Issues

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 NYSOH 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)).

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 Federal Register 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 is whether NYSOH properly determined that you, your spouse, and your daughter were eligible for an APTC of up to $947.00 per month.

The application that was submitted on June 2, 2017 listed an annual household income of $77,999.99 and the eligibility determination relied upon that information.

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

You reside in Sullivan County, where the second lowest cost silver plan available for a couple and one dependent through NYSOH costs $1576.79 per month.

An annual income of $77,999.99 is 386.90% of the 2016 FPL for a three-person household. At 386.90% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or $629.85 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH a couple and one dependent in your county ($1576.79 per month) minus your expected contribution ($629.85 per month), which equals $946.94 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you, your spouse, and your daughter to be eligible for up to $947.00 per month in APTC.

The second issue is whether you, your spouse, and your daughter 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 $77,999.99 is

386.90% of the applicable FPL, NYSOH correctly found you, your spouse, and your daughter to be ineligible for cost sharing reductions.

Since the June 3, 2017 eligibility determination properly stated that, based on the information you provided, you, your spouse, and your daughter were eligible for up to $947.00 per month in APTC, and ineligible for cost-sharing reductions, it is correct and is AFFIRMED.

The third issue is whether NYSOH properly determined that your family's plan premium is $1,138.83 per month.

On January 21, 2017, NYSOH issued a notice of enrollment stating that you, your spouse, your son, and your daughter were enrolled in a Fidelis Care bronze family plan with a plan premium of $1,138.83 per month.

On June 2, 2017, you removed your son from your NYSOH account.

On June 3, 2017, NYSOH issued a notice of enrollment stating that you, your spouse, and your daughter were enrolled in a Fidelis Care bronze family plan with a plan premium of $1,138.83.

During the hearing, you requested that your plan premium be reduced as of July 1, 2017 as there were now three people enrolled in your Fidelis Care bronze family plan rather than four people.

NYSOH Appeals Unit only has the authority to review issues related to the following: (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 to provide timely notice of an eligibility determination and (5) a denial of a special enrollment period.

Since the Appeals Unit is not given the authority to review premium amounts of qualified health plans, we cannot reach the merits as to whether or not your family's Fidelis Care bronze level family plan premium should be reduced. Therefore, your appeal of the June 3, 2017 enrollment notice is DISMISSED as a non-appealable issue.

Decision

Your appeal of the insurer's plan premium is DISMISSED as a non-appealable issue.

The June 3, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 20, 2017

How this Decision Affects Your Eligibility

You, your spouse, and your daughter remain eligible for up to $947.00 per month in APTC.

You, your spouse, and your daughter are ineligible for cost-sharing reductions.

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

Your appeal of the insurer's plan premium is DISMISSED as a non-appealable issue.

You, your spouse, and your daughter remain eligible for up to $947.00 per month in APTC.

You, your spouse, and your daughter are ineligible for cost-sharing reductions.

The June 3, 2017 eligibility determination notice is AFFIRMED.

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.

□□□□□ (Bengali)

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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).