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

Notice of Decision

Decision Date: December 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022475

[redacted]

[redacted]

On November 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 9, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: December 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022475

[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 were eligible to receive up to $98.00 per month in advance payments of the premium tax credit, effective October 1, 2017?
>
> Did NY State of Health properly determine that you were ineligible for cost-sharing reductions?

Procedural History

On June 22, 2017, you submitted an application for financial assistance.

Also on June 22, 2017, you uploaded income documentation to your NY State of Health (NYSOH) account.

On June 23, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $326.00 per month in advance payments of the premium tax credit (APTC) for a limited time and cost-sharing reductions for a limited time if you enrolled in a silver level qualified health plan, effective August 1, 2017. This notice directed you to submit proof of your income by September 20, 2017 in order to confirm your eligibility for financial assistance.

Also on June 23, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On June 24, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your account and that additional documentation was required by September 20, 2017 in order to confirm your eligibility for financial assistance.

Also on June 24, 2017, NYSOH issued a notice of eligibility redetermination stating that you were eligible to receive up to $328.00 per month in APTC for a limited time and cost-sharing reductions for a limited time if you enrolled in a silver level qualified health plan, effective August 1, 2017. This notice directed you to submit proof of your income by September 20, 2017 in order to confirm your eligibility for financial assistance.

On August 29, 2017, you updated your application for financial assistance.

Also on August 29, 2017, you uploaded income documentation to your NYSOH account.

On August 30, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $326.00 per month in APTC for a limited time and cost-sharing reductions for a limited time if you enrolled in a silver level qualified health plan, effective October 1, 2017. This notice directed you to submit proof of your income by September 20, 2017 in order to confirm your eligibility for financial assistance.

Also on August 30, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On August 31, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your account and that additional documentation was required by September 20, 2017 in order to confirm your eligibility for financial assistance.

Also on August 31, 2017, NYSOH issued a notice of eligibility redetermination stating that you were eligible to receive up to $310.00 per month in APTC for a limited time and cost-sharing reductions for a limited time if you enrolled in a silver level qualified health plan, effective October 1, 2017. This notice directed you to submit proof of your income by September 20, 2017 in order to confirm your eligibility for financial assistance.

On September 6, 2017, you updated your application for financial assistance.

On September 7, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $321.00 per month in APTC for a limited time and cost-sharing reductions for a limited time if you enrolled in a silver level

qualified health plan, effective October 1, 2017. This notice directed you to submit proof of your income by September 20, 2017 in order to confirm your eligibility for financial assistance.

On September 8, 2017, you uploaded income documentation to your NYSOH account.

Also on September 8, 2017, NYSOH reviewed the income documentation you submitted, recalculated your income based on this documentation, updated the income listed in your application based on this recalculation, and submitted an application on your behalf.

On September 9, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $98.00 per month in APTC, effective October 1, 2017. That notice also stated that you were not eligible for cost-sharing reductions because your income was over the allowable income limit for that program.

On September 15, 2017, you spoke to NYSOH's Account Review Unit and appealed the amount of APTC for which you were eligible.

On November 28, 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 single and you will not claim any dependents on that tax return.

2) You are seeking insurance for yourself.

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

4) Your [redacted] County.

5) The applications that you submitted on June 22, 2017 and August 29, 2017 listed annual household income of $24,000.00, consisting of $2,000.00 per month you expected to earn from your employment at [redacted].

6) On June 22, 2017, you uploaded your 2016 tax return to your NYSOH account. Your 2016 1040 lists gross wages of $5,634.00, business income of $1,378.00, and a deduction of $98.00 for the deductible part of the self-employment tax, for an adjusted gross income of $6,914.00.

7) On June 23, 2017, NYSOH determined that your tax return was insufficient proof of your 2017 income as you were attesting to income from an employer, therefore four weeks of paystubs were required.

8) On August 29, 2017, you uploaded one paystub to your NYSOH account from [redacted] for pay date September 1, 2017 for pay period August 5, 2017 to August 18, 2017 for a gross pay amount of $1,126.70.

9) On August 30, 2017, NYSOH determined that this single paystub was insufficient as the required documentation was two biweekly paystubs.

10) The application that you submitted on September 6, 2017 listed annual household income of $24,500.00, consisting of $2,000.00 per month you expected to earn from your employment at [redacted] and $500.00 you expected to earn from self-employment.

11) On September 8, 2017, you uploaded income documentation to your NYSOH account consisting of one paystub from [redacted] for pay date August 18, 2017 for pay period July 22, 2017 to August 4, 2017 for a gross pay amount of $2,254.30 and a time sheet from [redacted]

12) On September 8, 2017, NYSOH reviewed the income documentation you submitted and determined that this was sufficient proof of your income as you had submitted two consecutive biweekly paystubs.

13) Also on September 8, 2017, NYSOH recalculated your income to be $44,441.30 based on the August 18, 2017 and September 1, 2017 paystubs as well as your attestation to $500.00 in self-employment income.

14) On September 26, 2017, you uploaded one paystub to your NYSOH from [redacted] for pay date September 15, 2017 for pay period August 19, 2017 to September 1, 2017 for a gross pay amount of $1,126.70.

15) On October 4, 2017, you uploaded a letter from [redacted] dated September 29, 2017 stating that from July 1, 2016 to June 30, 2017 you earned a gross pay of $20,318.60.

16) On November 28, 2017, you uploaded three biweekly paystubs from [redacted] to your NYSOH account; the first is for pay date October 24, 2017 for a gross pay amount of $330.00; the second is for pay date November 9, 2017 for a gross pay amount of $330.00; the third is for pay date November 22, 2017 for a gross pay amount of $275.00.

17) You testified that you work from September to June for [redacted] You testified that from September 2016 to June 2017 you earned $20,318.60 and from September 1, 2017 to June 30, 2017 you have an agreement to be paid $24,000.00. You explained that you do not work summers for this employer, and work approximately 40 weeks per year. You went on to testify that although your paystub indicates that you are paid on an hourly basis, you are actually salaried and receive $1,126.70 gross per biweekly pay period.

18) You testified that the paystub for pay date August 18, 2017 reflects a gross pay amount of $2,253.40 as this paystub actually reflects four weeks of pay, two weeks from August and two weeks from June.

19) You testified that your self-employment income for 2017 has decreased, and you now anticipate earning $300.00 from your self-employment in 2017.

20) You testified that you began working for [redacted] in September 2017. You are paid on a biweekly basis and your pay varies based on how many hours you work. You testified that you will earn $5,000.00 from this job from September 2017 to June 2018.

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 $11,880.00 for a one-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).

<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)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to $98.00 per month.

As of September 8, 2017, your NYSOH account contained your 2016 tax return, your paystubs for pay dates August 18, 2017 and September 1, 2017 from [redacted]

The application that you submitted on September 6, 2017 listed annual household income of $24,500.00, consisting of $2,000.00 per month you expected to earn from your employment at [redacted] $500.00 you expected to earn from self-employment.

On September 8, 2017, NYSOH calculated your annual expected income to be $44,441.30. This was based on two biweekly paystubs showing a combined gross pay amount of $3,380.10 divided by four weeks for an average gross weekly pay of $845.025, multiplied by 52 weeks for a gross yearly income from [redacted] of $43,941.30 and $500.00 in self-employment income.

Although you later submitted a letter from [redacted] showing that you only work during the school year from September until June, this was not submitted until October 4, 2017. Furthermore, the applications you submitted on June 22, 2017, August 29, 2017, and September 6, 2017 do not indicate that your work with [redacted] was not year-round.

Additionally, you testified that the paystub you submitted from August 18, 2017 represented your pay for two pay periods. However, the August 18, 2017 paystub indicates that this is for the pay period from July 22, 2017 to August 4, 2017.

Therefore, based on the applications you submitted prior to September 8, 2017 and the documentation that was available in your NYSOH account as of September 8, 2017, NYSOH correctly determined your annual expected income to be $44,441.30.

You expect to file your 2017 income taxes as single and will not claim any dependents on that tax return. Therefore, you are in a one-person household.

You reside in [redacted], where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $44,441.30 is 374.09% of the 2016 FPL for a one-person household. At 374.09% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or $358.86 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 ($456.46 per month) minus your expected contribution ($358.86 per month), which equals $97.60 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $98.00 per month in APTC.

The second issue is whether you 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 $44,441.30 is 374.09% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

Since the September 9, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $98.00 per month in APTC and ineligible for cost-sharing reductions, it is correct and is AFFIRMED.

Following your appeal of the September 9, 2017 eligibility determination you updated your application and submitted additional documentation of your income. You also provided information that you are not a fifty-two week worker.

As we are now in the 2018 enrollment period, the NYSOH Appeals Unit cannot direct NYSOH to redetermine your eligibility for 2017. If you have used APTC to help pay for health insurance premiums in 2017, you must file a federal tax return. Your APTC, regardless of whether correctly or incorrectly determined by NYSOH, will be reconciled on your 2017 tax return by the IRS.

Decision

The September 9, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: December 01, 2017

How this Decision Affects Your Eligibility

This decision has no impact on subsequent eligibility determinations in your account.

As we are now in the 2018 enrollment period, the NYSOH Appeals Unit cannot direct NYSOH to redetermine your eligibility for 2017. If you have used APTC to help pay for health insurance premiums in 2017, you must file a federal tax return. Your APTC, regardless of whether correctly or incorrectly determined by NYSOH, will be reconciled on your 2017 tax return by the IRS.

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 September 9, 2017 eligibility determination notice is AFFIRMED.

This decision has no impact on subsequent eligibility determinations in your account.

As we are now in the 2018 enrollment period, the NYSOH Appeals Unit cannot direct NYSOH to redetermine your eligibility for 2017. If you have used APTC to help pay for health insurance premiums in 2017, you must file a federal tax return. Your APTC, regardless of whether correctly or incorrectly determined by NYSOH, will be reconciled on your 2017 tax return by the IRS.

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.

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 नि:शुल्क 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)

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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