



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

**Notice of Decision**

Decision Date: February 14, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000025022

[REDACTED]

[REDACTED]

On January 22, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health’s November 1, 2017 plan enrollment 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 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.

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

## Decision

Decision Date: February 14, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000025022

[REDACTED]

## Issue

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

Did NY State of Health (NYSOH) properly change the amount of advance payment of premium tax credits (APTC) applied for the months of November 2017 and December 2017?

## Procedural History

According to your NYSOH account, in December 2016, you were determined eligible to receive up to \$274.00 per month in APTC and eligible for cost-sharing reductions, for a limited time, effective January 1, 2017. You were enrolled in a silver-level qualified health plan (QHP), effective January 1, 2017, with the maximum amount of APTC applied as of January 1, 2017.

On September 22, 2017, NYSOH issued a renewal notice stating that it was time for a member of your household to renew their health insurance coverage through NYSOH. This notice further stated that, based on state and federal data sources obtained as of September 21, 2017, you were eligible for up to \$125.46 per month of APTC, effective December 1, 2017. The notice stated that you were enrolled into silver-level QHP with the insurance provider: Empire Blue Cross Blue Shield (Medical Downstate) so that you would not have any interruptions in your coverage. The plan name was Empire BlueCross BlueShield HMO 2800 X, for HSA, Silver, NS, INN, Pediatric Dental, Dep 25, a Multi-State plan. This notice stated that you qualified for a maximum of \$125.46 of APTC to be applied to your monthly premium, and that all or part of this credit could be applied to your monthly premium for this QHP. This notice also stated that any income-based

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cost-sharing reductions (lower copayments, coinsurance and deductibles) with your current plan would no longer be available after November 30, 2017, and your current coverage would end as of December 31, 2017. This notice further indicated that you would get a notice about renewing your coverage around November 16, 2017.

On October 18, 2017, NYSOH issued a plan enrollment notice confirming, in part, your enrollment in a silver-level QHP with \$125.46 in APTC applied to your monthly premium, effective November 1, 2017.

On October 31, 2017, NYSOH received your updated application for financial assistance with health insurance.

On November 1, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for up to \$248.00 per month in APTC and cost-sharing reductions if you enrolled into a silver-level QHP, for a limited time, effective November 1, 2017. This notice further directed you to submit income documentation by January 29, 2018 to confirm your eligibility.

Also on November 1, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a silver-level QHP with a premium amount of \$456.11 after \$125.46 of your APTC was applied to your monthly premium, effective November 1, 2017.

On November 29, 2017, you spoke to NYSOH's Accounts Review Unit and appealed the amount of APTC that was applied to your monthly premiums for the months of November 2017 and December 2017.

On January 22, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was closed at the end of the hearing.

## **Findings of Fact**

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

- 1) After your APTC of \$274.00 per month was applied to your QHP as of January 1, 2017, your monthly premium responsibility was \$307.57.
- 2) According to your NYSOH account, on September 21, 2017, NYSOH ran an application on your behalf in order to renew your child's Child Health Plus plan coverage.
- 3) According to your NYSOH account, on September 22, 2017, NYSOH issued a renewal notice stating in part that, based on state and federal data sources, you qualified for a maximum of \$125.46 in APTC.

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- 4) According to your NYSOH account, on October 18, 2017, NYSOH issued a plan enrollment notice, which confirmed your enrollment in a silver-level QHP with the maximum amount (\$125.46) of APTC applied to your monthly premium, effective November 1, 2017. The monthly premium for this plan after your APTC was applied was \$456.11.
- 5) After this reenrollment, you testified that you realized that your QHP deductible and your monthly premium amount had increased, which caused you contacted NYSOH on October 31, 2017, to update your application and to be reenrolled into the QHP you had since January 1, 2017.
- 6) On October 31, 2017, you updated your NYSOH account after the update made by NYSOH on September 21, 2017. In this application, you updated the income amount to \$35,143.00. A preliminary eligibility determination was prepared that day finding you eligible to receive up to \$248.00 per month in APTC, for a limited time, effective November 1, 2017.
- 7) According to your NYSOH account, on November 1, 2017, NYSOH issued a plan enrollment notice which confirmed your enrollment in a silver-level QHP with only \$125.46 applied to your monthly premium, effective November 1, 2017. The monthly premium for this plan after your APTC was applied was \$456.11.
- 8) You testified that, when you contacted NYSOH on October 31, 2017, your main concern was getting re-enrolled into the QHP that you had since January 1, 2017.
- 9) You testified that, when you were informed by the NYSOH representative that you were to be re-enrolled into the same plan you had as of January 2017, you thought this meant the original total amount of APTC of \$274.00 per month would be applied as well.
- 10) You testified that you have already paid your QHP the premium amount of \$456.11 for November 2017 and December 2017 each.
- 11) You testified that you are seeking to have \$274.00 per month in APTC retroactively applied to your November 2017 and December 2017 premium.

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 \$16,020.00 for a two-person household (81 Federal Register 4036.).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution for 2017 is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

### Redetermination During a Benefit Year

When a redetermination is issued as a result of a change in an applicant's information, NYSOH must generally make that redetermination effective on the first day of the month following the date NYSOH is notified of the change (45

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CFR § 155.330 (f)(1)(ii)). However, NYSOH may determine that its policy will be that any change made after the 15<sup>th</sup> of any month will not be effective until the first of the second following month (45 CFR § 155.330(f)(2)).

When an eligibility redetermination results in a change in the amount of advance payments of the premium tax credit (APTC) for the benefit year, NYSOH must recalculate the amount of APTC in such a manner as to account for any advance payments already made on behalf of the tax filer, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for that benefit year (45 CFR § 155.330(g)).

### End of Tax Year Reconciliation

At the end of a tax year, a person who elects to take the advance premium tax credit to help pay for the cost of an insurance premium must file a tax return to reconcile any differences between the amount of income the person reported to NYSOH and their actual gross income for that year. A person who received less tax credit than her maximum entitlement, based on gross income, may receive an income tax refund, or owe less in taxes. A person who received more tax credit than his maximum entitlement, based on gross income, will owe the excess as an additional income tax liability (26 CFR § 1.36B-4).

## **Legal Analysis**

The issue under review is whether NYSOH properly applied your APTC to your monthly premiums for November 2017 and December 2017.

The record indicates that you were originally found eligible for \$274.00 per month in APTC, effective January 1, 2017. However, NYSOH reran your application on September 21, 2017, based on state and federal data sources, when it renewed your child's Child Health Plus plan coverage. Based on federal and state data sources, your income changed from what you had attested to in December 2016. On September 22, 2017, NYSOH issued an eligibility determination notice, based on the system run on September 21, 2017, stating that you were eligible for up to \$125.46 per month in APTC.

The record indicates that you submitted an updated application on October 31, 2017, which listed an annual expected income of \$35,143.00, and you were found eligible for up to \$248.00 per month in APTC, effective November 1, 2017. However, NYSOH also issued a plan enrollment notice on November 1, 2017, confirming your enrollment in your QHP with a monthly premium amount of \$456.11, after applying only \$125.46 in APTC, effective November 1, 2017.

During the hearing, you testified that you are appealing the amount of APTC that was applied to your monthly premium for November 2017 and December 2017

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insofar as it was less than the maximum APTC amount you were eligible to receive. Based on your testimony, it is concluded that you are only appealing the amount of APTC that was applied to your monthly premium for the months of November 2017 and December 2017, which amount was \$125.46, and not the amount of APTC you were found eligible for as indicated in the November 1, 2017 eligibility determination notice, which amount was \$248.00, or the initial amount of \$274.00 as of January 1, 2017.

You testified that, when NYSOH reran your eligibility on September 21, 2017, they did so without your knowledge or consent. You testified that after this update, NYSOH enrolled you into a different QHP, which is what caused you to contact them. You testified that, on October 31, 2017, you informed NYSOH that you would like to be reinstated in the QHP you had prior to the September 21, 2017 update and you assumed that this meant your APTC amount would also return to its original amount of \$274.00. You further testified that when you became aware your premium responsibility for November 2017 and December 2017 was significantly higher than previous months, you contacted NYSOH and they informed you to file an appeal. You also testified that you had already paid the portion of your premium responsibility to your QHP of \$456.11 for November 2017 and December 2017 each.

Based on the information in your NYSOH account as of October 31, 2017, you were found eligible for a greater amount of APTC (\$248.00) than was applied (\$125.46) to your health insurance premium in the months of November 2017 and December 2017. However, this is no indication in the record that you attempted to increase the amount of APTC applied to your monthly premium for the months of November 2017 or December 2017. You testified that you believed by requesting to be re-enrolled in the same QHP you had in January 2017, that your monthly APTC amount would be restored also. You further testified that you paid the premium responsibility of \$456.11 each month to the QHP, which was your portion of monthly premium after APTC of \$125.46 was applied.

Therefore, since there is no indication in the record that you affirmatively requested that the amount of APTC being applied to your monthly premium payment for November 2017 and December 2017, be increased, the November 1, 2017 plan enrollment notice is **AFFIRMED**.

It is important to note that when you receive APTC, you are actually receiving, in advance, the benefit of a tax deduction you would ordinarily not receive until after the year is over when you file your tax return. The credit is given to you in advance, so that you can afford to get the coverage.

NYSOH tries to estimate, as closely as possible, what your ultimate tax credit will be, so that your receipt of APTC in advance will not have an excessive impact on any tax payment or refund you have at the end of the year. This calculation could involve the use of state and federal data sources to estimate the amount of



APTC you are eligible for. Ultimately, however, the IRS determines what your tax credit will be for the completed year.

After you received the APTC as a credit against your health insurance premiums, you then were required to file a federal tax return, in which the total of the monthly APTC you received is reconciled with the tax credit associate with your actual reported annual income for the year. If you received too much APTC in advance, the excess will decrease the amount of your tax return, or increase the payment you owe.

Since the record indicates that you may have been eligible for a greater amount of APTC than was applied to your monthly premium for November 2017 and December 2017, any difference between the APTC applied (based on your expected 2017 income) and the premium tax credit you can claim on your 2017 federal tax return (based on your actual 2017 income) should be reconciled on your 2017 federal tax return, which includes the APTC amount for the months of November 2017 and December 2017.

## **Decision**

The November 1, 2017 plan enrollment notice is AFFIRMED.

This Decision has no effect on any subsequent eligibility determination or plan enrollment notices issued by NYSOH.

**Effective Date of this Decision:** February 14, 2018

## **How this Decision Affects Your Eligibility**

This Decision does not affect your current eligibility.

You were found eligible for up to \$248.00 per month in APTC for the months of November 2017 and December 2017, based on the information you provided in your October 31, 2017 application.

The monthly premium amount you were responsible for in November 2017 and December 2017 only included \$125.46 in APTC.

Any discrepancies in the amount of APTC you were entitled to and the amount of APTC you received will be corrected when you file your 2017 federal tax return, which will include your APTC for the months of November 2017 and December 2017.

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## **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

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Albany, NY 12211

- By fax: 1-855-900-5557

## **Summary**

The November 1, 2017 plan enrollment notice is AFFIRMED.

This Decision has no effect on any subsequent eligibility determination or plan enrollment notices issued by NYSOH.

This Decision does not affect your current eligibility.

You were found eligible for up to \$248.00 per month in APTC for the months of November 2017 and December 2017, based on the information you provided in your October 31, 2017 application.

The monthly premium amount you were responsible for in November 2017 and December 2017 only included \$125.46 in APTC.

Any discrepancies in the amount of APTC you were entitled to and the amount of APTC you received will be corrected when you file your 2017 federal tax return; which will include your APTC for the months of November 2017 and December 2017.

## **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.

**A Copy of this Decision Has Been Provided To:**



## 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)

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### 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 مجاناً.

### 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।

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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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye srɛ wo, frɛ 1-855-355-5777. yɛbɛtumi ama wo obi a okyerɛ 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.

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