



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

## Notice of Decision

Decision Date: April 15, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000005350

[REDACTED]

Dear [REDACTED],

On February 2, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's November 24, 2015 eligibility determination.

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.

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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## Decision

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NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000005350



## Issues

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

Did New York State of Health (NYSOH) properly determine that you were eligible to receive up to \$152.00 per month in advance payments of the premium tax credit, effective January 1, 2016?

Did NYSOH properly determine that you were eligible to receive cost-sharing reductions, effective January 1, 2016?

Did NYSOH properly determine that you were not eligible for the Essential Plan?

## Procedural History

On November 6, 2015 NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a \$20 per month premium, based on annual income \$28,774.60. This eligibility was effective January 1, 2016.

On November 23, 2015 the income information in your NYSOH account was updated.

On November 24, 2015, NYSOH issued an eligibility determination notice based on your November 23, 2015 application, stating that you were eligible for APTC in the amount of \$152.00 per month, effective January 1, 2016. This notice also

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stated that you were eligible for CSR effective January 1, 2016 if you enrolled in a silver level QHP.

On November 25, 2015, you contacted the NYSOH's Account Review Unit and requested an appeal of that eligibility determination with regard to the level of financial assistance for which you were determined eligible.

On February 2, 2016, 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 2016 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.
- 2) You are seeking insurance for yourself only.
- 3) You testified that you are appealing because you want coverage through the Essential Plan.
- 4) The application that was submitted on November 23, 2015 listed annual household income of \$37,872.00, consisting of \$15,204.00 you receive from Social Security disability benefits, \$15,309.60 that your spouse receives in Social Security retirement benefits, and \$7,368.00 that your spouse receives in additional income, and which you testified was the total of two pensions. You testified that this amount was correct.
- 5) Your application states that you will not be taking any deductions on your 2016 tax return, and you confirmed this in your testimony.
- 6) Your application states that you live in Onondaga County.
- 7) In the application that was submitted on November 23, 2015, NYSOH stated that you were not eligible for the Essential Plan because you were over income.

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 2016 is set by federal law at 2.03% to 9.66% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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 2015 FPL, which is \$15,930.00 for a two -person household (80 Fed. Reg. 3236, 3237).

For annual household income in the range of at least 200% but less than 250% of the 2015 FPL, the expected contribution is between 6.41% and 8.18% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

### 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,

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(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)).

### Essential Plan

NYSOH must determine an applicant eligible for the Essential Plan if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable FPL or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is under the age of 64, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e)).

In an analysis of Essential Plan eligibility, the determination is based on the FPL for the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2015 FPL, which is \$15,930.00 for a two-person household (80 Fed. Reg. 3236, 3237).

### **Legal Analysis**

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to \$152.00 per month.

The application that was submitted on November 23, 2015 listed an annual household income of \$37,872.00, and the eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2016 income taxes as married filing jointly and will not claim any dependents on that tax return.

You reside in Onondaga County, where the second lowest cost silver plan available for an individual through NYSOH costs \$396.54 per month.

An annual income of \$37,872.00 is 237.74% of the 2015 FPL for a two-person household. At 237.74% of the FPL, the expected contribution to the cost of the health insurance premium is 7.75% of income, or \$244.59 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 subscriber in your county (\$396.54 per month) minus your expected contribution (\$244.59 per month), which equals \$151.95 per month. Therefore, rounding to

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the nearest dollar, NYSOH correctly determined you to be eligible for up to \$152.00 per month in APTC.

The second issue is whether you were properly found 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 \$37,871.60 is 237.74% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether you were eligible for the Essential Plan.

In the application that was submitted on November 23, 2015, NYSOH stated that you were not eligible for the Essential Plan because your income exceeded the limit for that program.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$15,930.00 for a two person household. Since \$37,871.60 is 237.74% of the 2015 FPL, you were not eligible for the Essential Plan as of your November 23, 2015 application.

Since the November 24, 2015 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$152.00 per month in APTC, and eligible for cost-sharing reductions, it is correct and is **AFFIRMED**.

## **Decision**

The November 24, 2015 eligibility determination notice is correct and is **AFFIRMED**.

**Effective Date of this Decision:** April 15, 2016

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

You remain eligible for \$152.00 in APTC.

You are eligible for cost-sharing reductions, if you enroll in a silver level QHP.

You are not eligible for the Essential Plan.

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## **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 November 24, 2015 eligibility determination notice is correct and is **AFFIRMED**.

You remain eligible for \$152.00 in APTC.

You are eligible for cost-sharing reductions, if you enroll in a silver level QHP.

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You are not eligible for the Essential Plan.

### **Legal Authority**

We are sending you this notice in accordance with 45 CFR § 155.545(a).

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

