



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

## Notice of Decision

Decision Date: December 19, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000009847

[REDACTED]

Dear [REDACTED],

On November 29, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's May 24, 2016 eligibility determination.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

### Legal Authority

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

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## Decision

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NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000009847



## Issues

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

Did New York State of Health (NYSOH) properly determine that you were eligible to receive up to \$0.00 monthly of advance premium tax credit as of May 24, 2016?

Did NYSOH properly determine that you were eligible for cost-sharing reductions as of May 24, 2016?

## Procedural History

On May 23, 2016, you submitted a financial assistance application through NYSOH. NYSOH rendered a preliminary eligibility stating, in relevant part, that you were eligible for up to \$0.00 monthly of advance premium tax credit and cost-sharing reductions.

Also on May 23, 2016, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as the amount of financial assistance you were determined eligible to receive.

On May 24, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible to receive up to \$0.00 monthly in advance premium tax credit and cost-sharing reductions, effective as of July 1, 2016.

On November 29, 2016 you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and the record was left open until November 30, 2016, to allow you to submit

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additional documentation to demonstrate your expected student loan interest deduction that you anticipate taking on your 2016 federal income tax return.

On December 1, 2016, a "Tax Return Transcript" for your spouse's 2014 FORM 1040A from the Internal Revenue Service (IRS) was uploaded to your NYSOH account ( [REDACTED] [REDACTED] [REDACTED] ). That documentation has been incorporated into the record as "Appellant Exhibit A." The record is now complete and closed.

## **Findings of Fact**

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

1. You testified that you are only appealing the amount of financial assistance you were determined eligible to receive through NYSOH.
2. According to your NYSOH account and testimony, you are applying for health insurance for yourself and your two children.
3. According to your May 23, 2016 financial assistance application, you plan on filing a 2016 federal income tax return, with the tax status of married filing jointly, and will be claiming your two children as dependents on that tax return.
4. According to your May 23, 2016 application, you attested to an expected 2016 annual household income of \$60,000.00.
5. You reside in Niagara County, New York.
6. You testified that your spouse is employed at [REDACTED] and expect their gross income to be \$39,620.00 in 2016.
7. You testified that you are employed at [REDACTED] and expect your gross income to be \$21,420.00 in 2016.
8. You testified that you are employed at the [REDACTED] and expect your gross income to be \$8,000.00 in 2016.
9. You testified that your spouse claimed a \$2,500.00 student loan interest deduction on their 2015 federal income tax return and expect them to claim the same deduction on your 2016 federal income tax return.
10. You testified that you are also repaying student loans, but not certain how much your student loan interest deduction would be for 2016.

11. You testified you are not able to afford the monthly health insurance premiums.

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

## **Applicable Law and Regulations**

### Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term “modified adjusted gross income” means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

### Student Loan Interest Deduction

“Adjusted gross income” is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, interest on a qualified educational loan can be deducted from adjusted gross income in an amount up to \$2,500 in interest paid by taxpayers during the taxable year, for individuals filing a joint tax return, whose yearly income does not exceed \$160,000 (26 USC § 221; see also 26 USC § 62 (17)).

### Advance Premium Tax Credit:

The advance premium tax credit is available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the 2015 federal poverty level; (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 qualified health plan; 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 the 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).

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 (see 26 CFR § 1.36B-3T(g)(1), (IRS Rev. Proc. 2014-62)).

In an analysis of APTC eligibility, the determination is based on the FPL "for the benefit year for which coverage is requested. (45 CFR § 155.305(f)(1)(i)). On the date of your application, that was the 2015 FPL, which is \$24,250.00 for a four-person household (80 Fed. Reg. 3236, 3237).

#### Cost-Sharing Reductions:

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through the Marketplace, (2) meets the requirements to receive advanced premium tax credits, (3) is expected to have an annual household income that does not exceed 250 percent of the FPL for the plan year coverage is requested and (4) is enrolled in a silver-level QHP (45 CFR § 155.305(g)(1)).

### **Legal Analysis**

The first issue is whether the NYSOH properly determined that you were eligible for up to \$0.00 monthly of APTC.

According to the record, you are in a four-person tax household. You expect to file your 2016 federal income tax return, with the tax status of married filing jointly, and expect to claim your two children as dependents on that return.

You reside in Niagara County, where the second lowest cost silver plan that is available through NYSOH for an individual costs \$353.19 per month.

The May 24, 2016 eligibility determination was based on an annual household income of \$60,000.00, which was the amount entered as your total household's expected annual income for 2016.

An annual household income of \$60,000.00 equals 247.42% of the 2015 FPL for a four-person household. At 247.42% of the FPL, the expected contribution to the cost of the health insurance premium is 8.09% of income, or \$404.50 per month.

The maximum amount of APTC that can be awarded equals the cost of the second lowest cost silver plan in your county (\$353.19 per month) minus your expected contribution (\$404.50 per month), which equals -\$51.31 per month. Therefore, NYSOH correctly computed your APTC to be \$0.00 per month.

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The second issue is whether NYSOH properly determined you eligible for cost-sharing reductions.

Cost-sharing reductions are available to a person who has an annual household income no greater than 250% of the FPL. Since your annual household income was 247.42% of the FPL for purposes for APTC and cost-sharing reductions, you were correctly found eligible for cost-sharing reductions.

Since the May 24, 2016 eligibility determination properly stated that you were eligible for up to \$0.00 of APTC per month and eligible for cost-sharing reductions, it was correct and is AFFIRMED.

However, at the hearing you testified to additional income information that was not a part of your initial application. You testified that you expected your spouse's gross income to be \$39,620.00, and your gross income to be (\$21,420.00 (+) \$8,000.00) \$29,420.00 in 2016. Therefore, your household's gross income is expected to be (\$39,620.00 (+) \$29,420.00) \$69,040.00 in 2016. You further testified that you expect to claim a student loan interest deduction in the amount of \$2,500.00. These amounts would result in a modified adjusted gross income (MAGI) of (\$69,040.00 (-) \$2,500.00) \$66,540.

Therefore, your case is RETURNED to NYSOH for a redetermination of your household's eligibility based on a four-person household in Niagara County with a household income of \$66,540.00.

## **Decision**

The May 24, 2016 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH for a redetermination of your household's eligibility based on a four-person household in Niagara County with a household income of \$66,540.00.

**Effective Date of this Decision:** December 19, 2016

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

You remain eligible to receive up to \$0.00 per month in APTC and eligible for cost-sharing reductions.

Your household eligibility will be redetermined based on a four-person household in Niagara County with a household income of \$66,540.00.

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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 after the date 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 date 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 May 24, 2016 eligibility determination is **AFFIRMED**.

You remain eligible to receive up to \$0.00 per month in APTC and eligible for cost-sharing reductions.

Your case is **RETURNED** to NYSOH for a redetermination of your household's eligibility based on a four-person household in Niagara County with a household income of \$66,540.00.

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## **Legal Authority**

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

