



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

## Notice of Decision

Decision Date: January 6, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000010922

[REDACTED]

[REDACTED]

On December 29, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's July 20, 2016 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).

This page intentionally left blank.



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

## Decision

Decision Date: January 6, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000010922

[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 \$195.00 per month in advance payments of the premium tax credit, effective September 1, 2016?

Did NY State of Health properly determine that you were eligible for cost-sharing reductions?

Did NY State of Health properly determine that you were ineligible for the Essential Plan?

## Procedural History

On July 19, 2016, NY State of Health (NYSOH) received your completed application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating that you were eligible for up to \$195.00 per month in tax credits to help pay for the cost of your health insurance as well as help paying for out of pocket costs if you selected a silver level health insurance plan.

Also on July 19, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the finding that you were eligible for advance payments of the premium tax credit rather than the Essential Plan.

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).

On July 20, 2016, NYSOH issued an eligibility determination notice based on the information contained in the July 19, 2016 application, stating that you were eligible to receive up to \$195.00 per month in advance payments of the premium tax credit (APTC) as well as cost sharing reductions if you selected a silver level qualified health plan, effective September 1, 2016.

On December 29, 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 single. You will claim no dependents on that tax return.
- 2) You are seeking insurance for yourself.
- 3) The application that was submitted on July 19, 2016 listed annual household income of \$26,250.00, consisting of \$14,220.00 you receive in Social Security Benefits and \$12,030 you receive from a pension.
- 4) You testified that this amount was not correct, and that you would actually receive \$26,864.64 in 2016 consisting of \$14,220.00 you receive in Social Security Benefits and \$12,644.64 you receive from a pension.
- 5) You testified that you will not be claiming any deductions on your 2016 taxes.
- 6) Your application states that you live in Erie County. You testified that you lived in Erie County throughout 2016.

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

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).

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 July 19, 2016 application, that was the 2015 FPL, which is \$11,770.00 for a one-person household (80 Federal Register 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).

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,

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).

(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 generally determine an applicant eligible for the Essential Plan, a basic health 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 federal poverty level (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 64 years old or younger, (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), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your July 19, 2016 application, that was the 2015 FPL, which is \$11,770.00 for a one-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 \$195.00 per month, effective September 1, 2016.

The application that was submitted on July 19, 2016 listed an annual household income of \$26,250.00 and the eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2016 income taxes as single and will claim no dependents on that tax return.

You reside in Erie County, where the second lowest cost silver plan available for an individual for 2016 through NYSOH costs \$353.19 per month.

An annual income of \$26,250.00 is 223.02% of the 2015 FPL for a one-person household. At 223.02% of the FPL, the expected contribution to the cost of the health insurance premium is 7.23% of income, or \$158.05 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 (\$353.19 per month) minus your expected contribution (\$158.05 per month), which equals \$195.14 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$195.00 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 \$26,250.00 is 223.02% of the 2015 FPL and a household income of \$26,864.64 is 226.13% of the 2016 FPL NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan.

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 2015 FPL was \$11,770.00 for a one-person household and the 2016 FPL was \$11,880 for a one-person household. Since an annual household income of \$26,250.00 is 223.02% of the 2015 FPL, and \$26,864.64 is 226.13% of the 2016 FPL NYSOH properly found you to be ineligible for the Essential Plan.

Since the July 20, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$195.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

## **Decision**

The July 20, 2016 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** January 6, 2017

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

You remain eligible for up to \$195.00 per month in APTC in 2016.

You are eligible for cost-sharing reductions.

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).

You are ineligible for the Essential Plan.

This decision has no effect on any subsequent determination made by NYSOH.

### **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 July 20, 2016 eligibility determination notice is **AFFIRMED**.

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).



You remain eligible for up to \$195.00 per month in APTC.

You are eligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

This decision has no effect on any subsequent determination made by NYSOH.

### **Legal Authority**

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

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

