



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

## Notice of Decision

Decision Date: January 24, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000012001

[REDACTED]

Dear [REDACTED],

On January 17, 2017 you appeared by telephone at a hearing on your appeal of NY State of Health's September 15, 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 24, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000012001



## 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 and your spouse were newly eligible to receive up to \$411.00 per month in advance payments of the premium tax credit, effective October 1, 2016?

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

## Procedural History

On September 14, 2016, NY State of Health (NYSOH) received your completed application for health insurance. That day, a preliminary eligibility determination was prepared with regard to the last application, stating that you and your spouse were newly eligible to receive advance premium tax credits of up to \$411.00 per month as well as cost sharing reductions effective October 1, 2016.

Also on September 14, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the level of financial assistance you were determined eligible to receive.

On September 15, 2016, NYSOH issued an eligibility determination notice based on the information contained in the September 14, 2016 application, stating that you and your spouse were newly eligible to receive advance premium tax credits of up to \$411.00 per month as well as cost sharing reductions effective October

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).

1, 2016. The determination stated you could select a health plan outside of the open enrollment period for 2016.

On January 17, 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 2016 taxes with a tax filing status of married filing jointly. You will claim two dependents on that tax return.
- 2) You are seeking insurance for you and your spouse.
- 3) The application that was submitted on September 14, 2016 listed annual household income of \$58,370.00, consisting of \$32,890.00 you earn from your employment and \$25,480.00 your spouse receives in income. You testified that this amount was correct.
- 4) You testified you receive approximately \$1,300.00 every two weeks. You testified your spouse currently receives \$14.00 an hour, based on 35 hours per week.
- 5) Your application states that you will be taking deductions on your 2016 tax return for student loan interest in the amount of \$100.00.
- 6) Your application states that you live in Onondaga County.

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

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).

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 \$ 24, 250.00 for a four-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, (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

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).

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 and your spouse were eligible for an APTC of up to \$411.00 per month.

The application that was submitted on September 14, 2016 listed an annual household income of \$58,370.00 and the eligibility determination relied upon that information.

You are in a four-person household. You expect to file your 2016 income taxes as married filing jointly and will claim two dependents on that tax return.

You reside in Onondaga County, where the second lowest cost silver plan available for a couple through NYSOH costs \$793.08 per month.

An annual income of \$58,370.00 is 240.70% of the 2015 Federal Poverty Level (FPL) for a four-person household. At 240.70% of the FPL, the expected contribution to the cost of the health insurance premium is 7.85% of income, or \$381.84 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 couple in your county (\$793.08 per month) minus your expected contribution (\$381.84 per month), which equals \$411.24 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to \$411.00 per month in APTC.

The second issue is whether you and your spouse 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 \$58,370.00 is 240.70% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

Since the September 15, 2016 eligibility determination notice properly stated that, based on the information you provided, you and your spouse were eligible for up to \$411.00 per month in APTC, and eligible for cost-sharing reductions, it is correct and is AFFIRMED.

## **Decision**

The September 15, 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).

**Effective Date of this Decision:** January 24, 2017

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

You and your spouse remain eligible for up to \$411.00 in APTC.

You and your spouse are eligible for cost-sharing reductions.

## **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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

## **Summary**

The September 15, 2016 eligibility determination notice is AFFIRMED.

You and your spouse remain eligible for up to \$411.00 in APTC.

You and your spouse are eligible for cost-sharing reductions.

## **Legal Authority**

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



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

