



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

## Notice of Decision

Decision Date: January 27, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013483

[REDACTED]

[REDACTED]

On January 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 23, 2016 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 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).

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## Decision

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NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013483

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## 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 son were eligible to receive up to \$507.00 per month in advance payments of the premium tax credit, effective January 1, 2017?

Did NY State of Health properly determine that you and your son were eligible for cost-sharing reductions, effective January 1, 2017?

## Procedural History

On November 22, 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 and your son were eligible for up to \$507.00 per month in advance payments of the premium tax credit as well as help paying for out of pocket expenses if you selected a silver-level health insurance plan, effective January 1, 2017.

Also on November 22, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the amount of advance payments of the premium tax credit for which you and your son were eligible.

On November 23, 2016, NYSOH issued an eligibility determination notice based on the information contained in the November 22, 2016 application, stating that you and your son were eligible for up to \$507.00 per month in advance payments

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of the premium tax credit as well as cost-sharing reductions if you selected a silver level qualified health plan, effective January 1, 2017.

On January 27, 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 2017 taxes with a tax filing status of head of household. You will claim one dependent on that tax return.
- 2) You are seeking insurance for yourself and your son.
- 3) The application that was submitted on November 22, 2016 listed annual household income of \$39,701.00, consisting of \$1,400.00 per month in gross income you receive from a pension and of wages you earn from your employment for which you are paid \$19.00 per hour and work approximately 21 to 24 hours per week. You testified that this amount was correct.
- 4) You testified that your son does not have any income and will not be filing a tax return. You testified that your son is currently enrolled in school.
- 5) You testified that you do pay for your son's school, however, the amount varies based upon the grants, loans, and other aid he is eligible for each semester. You testified that you also purchase a Metro North Pass so that your son can travel to and from his campus.
- 6) You testified that you believe you will be taking deductions on your 2017 tax return for tuition, however, you were not sure of the amount of these deductions.
- 7) You testified that you reside in Queens 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

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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 Fed. Reg. 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution 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).

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-4T).

## 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 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 son were eligible for an APTC of up to \$507.00 per month.

The application that was submitted on November 22, 2016 listed an annual household income of \$39,701.00 and the eligibility determination relied upon that information.

You and your son are in a two-person household. You expect to file your 2016 income taxes as head of household and will claim one dependent on that tax return.

You reside in Queens County, where the second lowest cost silver plan available for a primary subscriber and one dependent through NYSOH costs \$775.97 per month.

An annual income of \$39,701.00 is 247.82% of the 2016 FPL for a two-person household. At 247.82% of the FPL, the expected contribution to the cost of the health insurance premium is 8.13% of income, or \$269.06 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 a primary subscriber and one dependent in your county (\$775.97 per month) minus your expected contribution (\$269.06 per month), which equals \$506.91 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$507.00 per month in APTC.

The second issue is whether you and your son 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 \$39,701.00 is 247.82% of the applicable FPL, NYSOH correctly found you and your son to be eligible for cost sharing reductions.

Since the November 23, 2016 eligibility determination properly stated that, based on the information you provided, you and your son were eligible for up to \$507.00 per month in APTC and eligible for cost-sharing reductions, it is correct and is **AFFIRMED**.

## **Decision**

The November 23, 2016 eligibility determination notice is **AFFIRMED**.

**Effective Date of this Decision:** January 27, 2017

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

You and your son remain eligible for up to \$507.00 per month in APTC.

You and your son 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.

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## **If You Have Questions about this Decision (Customer Service Resources):**

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## **Summary**

The November 23, 2016 eligibility determination notice is AFFIRMED.

You and your son remain eligible for up to \$507.00 per month in APTC.

You and your son 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:**

