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

Notice of Decision

Decision Date: March 15, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000013948

Dear ,

On March 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 13, 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: March 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013948

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were eligible to receive $0.00 per month in advance payments of the premium tax credit (APTC), effective January 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?

Procedural History

On December 1, 2016, you updated your application for financial assistance.

On December 2, 2016, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to receive up to $440.00 per month in APTC, effective January 1, 2017.

On December 12, 2016, you updated your application for financial assistance, and indicated that your spouse was not applying for health insurance. That day, a preliminary eligibility determination was prepared stating that you were eligible to receive $0.00 per month in APTC, effective January 1, 2017.

Also on December 12, 2016, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination, insofar as you were not eligible for a higher level of APTC.

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On December 13, 2016, NYSOH issued a notice of eligibility determination, based on the December 12, 2016 application, stating that you were eligible to receive $0.00 per month in APTC. The notice also stated that you were ineligible to receive cost-sharing reductions because your income was over the allowable income limits for that program.

On March 9, 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 married filing jointly. You will claim two dependents on that tax return.

2) You are seeking insurance for yourself only, as your spouse has coverage available through her employer.

3) The application that was submitted on December 12, 2016 listed annual household income of $65,000.00, consisting of income that your spouse earns. You testified that this amount was correct.

4) You testified that you started working at a job sometime around the end of December 2016 because you needed to try to earn money to pay for health insurance.

5) You testified that you are paid biweekly, and that your gross biweekly pay is $450.00.

6) Your application states that you will not be taking any deductions on your 2017 tax return.

7) Your application states that you live in Richmond County.

8) You testified that you originally applied for financial assistance for yourself and your spouse because you did not know that she would not be eligible for financial assistance if she had insurance coverage available through her employer.

9) You testified that you do not understand why removing her from your application changed your tax credit from over $400.00 to $0.00, when your household size and income did not change.

10) You testified that you would like to be eligible for financial assistance with paying for the cost of health insurance.

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

APTC is 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 $24,300.00 for a four-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% 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-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 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 under review is whether NYSOH properly determined that you were eligible for an APTC of $0.00 per month.

The application that was submitted on December 12, 2016 listed an annual household income of $65,000.00 and the eligibility determination relied upon that information.

You are in a four-person household. You expect to file your 2017 income taxes as married filing jointly and will claim two dependents on that tax return.

You reside in Richmond County, where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $65,000.00 is 267.49% of the 2016 FPL for a four-person household. At 267.49% of the FPL, the expected contribution to the cost of the health insurance premium is 8.73% of income, or $472.88 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 ($456.46 per month) minus your expected contribution ($472.88 per month), which equals a negative dollar amount. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for $0.00 per month in APTC.

The second issue under review is whether you were properly found ineligible 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 $65,000.00 is 267.49% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

You testified at the hearing that you did not understand why you could not choose for your spouse to have financial assistance with insurance coverage through NYSOH.

An individual is only eligible for APTC if they are not otherwise eligible for minimum essential coverage. Since your spouse has employer-sponsored health insurance that was found to be minimum essential coverage, she is not eligible to receive tax credits to purchase health insurance through NYSOH.

You also testified that you do not understand why your APTC amount was reduced when you removed your spouse from the application, as your household size and income remained the same.

APTC is based not only on household size and income, but also on the cost of the second lowest cost silver plan available in your county for your specific policy size. In Richmond County, the second lowest cost silver plan for a couple costs $912.91. Since your expected monthly contribution is $472.88, this was subtracted from $912.91 to give you and your spouse an APTC of up to $440.00 per month.

However, since the second lowest cost silver plan for an individual in Richmond County is $456.46 per month, subtracting your expected monthly contribution of $472.88 led to a negative number, which is why you are eligible for $0.00 in APTC. Your APTC amount decreased because the cost of the plan decreased.

Since the December 13, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for $0.00 per month in APTC, and ineligible for cost-sharing reductions, it is correct and is AFFIRMED.

Decision

The December 13, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 15, 2017

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How this Decision Affects Your Eligibility

You remain eligible for $0.00 in APTC.

You are ineligible 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
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The December 13, 2016 eligibility determination notice is AFFIRMED.

You remain eligible for $0.00 in APTC.

You are ineligible for cost-sharing reductions.

Legal Authority

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A Copy of this Decision Has Been Provided To:

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