STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026814

[redacted]

Dear [redacted]

On March 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 17, 2017 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
  PO 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 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(b).

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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Decision

Decision Date: March 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026814

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that you and your spouse were eligible to receive up to $566.00 per month in advance payments of the premium tax credit, and not eligible for the Essential Plan, effective February 1, 2018?

Procedural History

On September 30, 2017, you applied for health insurance and financial assistance through NYSOH.

On October 1, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to enroll in the Essential Plan with a $20.00 premium per month for a limited time, effective November 1, 2017. You were requested to provide proof of your household income to NYSOH by December 29, 2017 to confirm you and your spouse's eligibility.

Also on October 1, 2017, NYSOH issued an enrollment notice confirming your selection of an Essential Plan for you and your spouse as of September 30, 2017. The notice stated that you and your spouse's Essential Plan coverage would begin effective November 1, 2017.

On December 10, 2017, NYSOH received a tax return transcript issued by the Internal Revenue Service (IRS) confirming the receipt of your tax return for 2016

on April 15, 2017. This tax return reflected an adjusted gross income of $45,725.00, after applying a $7,500.00 deduction for contributions to your IRA.

On December 17, 2017, NYSOH received (1) four earnings statements issued to you by your first employer, [redacted] between November 22, 2017 and December 13, 2017, and (2) four earnings statements issued to you by your second employer, [redacted] between November 24, 2017 and December 15, 2017.

On December 16, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On December 17, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were found eligible for an advance premium tax credit of up to $566.00 per month, effective February 1, 2018. The notice also stated that you and your spouse were no longer eligible for the Essential Plan since your household income exceeded the allowable limit for that program.

Also on December 17, 2017, NYSOH issued a disenrollment notice confirming that you and your spouse's coverage under the Essential Plan would end effective January 31, 2018.

On January 5, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you and your spouse were found not eligible for the Essential Plan.

On March 21, 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 support the following findings of fact:

1) You testified that you expect to file your tax return for 2018 with a tax filing status of married filing jointly. You will claim your two children as dependents on that tax return.

2) You are seeking insurance for you and your spouse, since your two children have already each been enrolled in Child Health Plus with a $9.00 monthly premium.

3) The application that was submitted on September 30, 2017 listed annual household income of $47,754,00, consisting of $25,254.00 you anticipate earning from your employment with [redacted]., and $22,500.00 you anticipate earning from your other employer, [redacted]

[redacted] You testified that these amounts were correct when provided.

4) In response to your September 30, 2017 application, NYSOH found you and your spouse conditionally eligible for the Essential Plan, pending receipt of income documentation by December 29, 2017 to confirm you and your spouse's eligibility.

5) On December 10, 2017, NYSOH received a tax return transcript issued by the IRS confirming receipt of your tax return for 2016 on April 15, 2017. This tax return reflected an adjusted gross income of $45,725.00, after applying a $7,500.00 deduction for contributions to your IRA.

6) On December 16, 2017, NYSOH received an update to your application for financial assistance with health insurance.

7) The application that was submitted on December 16, 2017 listed annual household income of $68,400.00, consisting of $2,250.00 per month you anticipate earning from your employment with [redacted]., and $3,450.00 per month you anticipate earning from your other employer, [redacted]. You testified that these amounts were correct when provided, but did not take into account the reduction of your gross income from [redacted] from your contributions to your IRA account.

8) On December 17, NYSOH issued an eligibility determination notice stating that you and your spouse had been found eligible for and APTC of up to $566.00 per month, effective February 1, 2018.

9) On December 17, 2017, NYSOH received four earnings statements issued to you by your first employer, [redacted] reflecting that you received $492.00 per week between November 22, 2017 and December 13, 2017. You testified this reflects your weekly salary from this employer.

10) On December 17, 2017, NYSOH received four earnings statements issued to you by your second employer, [redacted], reflecting that you received $760.00 per week between November 24, 2017 and December 15, 2017. You testified this reflects your weekly salary from this employer. These earnings statements also reflect that your income he been reduced by a total of $18,000.00 from pretax contributions to your IRA.

11) Your application states that you will not be taking any deductions on your 2018 tax return; however, you testified and provided income documentation reflecting that you took $7,500.00 in IRA contributions during 2016, and had contributed $18,000.00 to your IRA during 2017.

[redacted]

You further testified that you anticipated contributing a similar amount during 2018.

12) You live in Nassau County, New York.

13) You testified that you believed you and your spouse ought to be eligible for the Essential Plan since the deductions relating to your IRA contributions reduced your anticipated adjusted gross income to approximately $45,000.00.

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 are generally 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 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

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 2017 FPL, which is $24,600.00 for a four-person household (82 Federal Register 8831).

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 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 application that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831).

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)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your spouse were eligible to receive up to $566.00 per month in APTC, and not eligible for the Essential Plan, effective February 1, 2018.

The application that was submitted on December 16, 2017 listed an annual household income of listed annual household income of $68,400.00, consisting of $2,250.00 per month you anticipate earning from your employment with [redacted] and $3,450.00 per month you anticipate earning from your other employer, [redacted]. You testified that these amounts were reasonably correct when provided, but did not consider the contributions to your IRA account from your employment with [redacted]. The earnings statements you provided to NYSOH on December 17, 2017 reflect that $18,000.00 of pretax contributions were made to your IRA. Indeed, while your gross salary approximately remained unaffected within these earnings statements, the year-to-date net pay figures reflect that your take-home pay had been reduced by at least $14,893.96 through December 15, 2018, which reasonably coincides with the $18,000.00 of pretax contributions were made to your IRA.

These IRA contributions would reduce your adjusted gross income for purposes of determining your modified adjusted gross income for 2018. Accordingly, we find that the original figure your provided in your September 30, 2017 application

of $47,754.00 to be a more appropriate anticipated annual income figure to determine your eligibility for financial assistance.

Since the December 17, 2017 eligibility determination and disenrollment notices are no longer supported by the record, they are RESCINDED.

Your case is RETURNED to NYSOH to (1) redetermine you and your spouse's eligibly for financial assistance based on a four-person household in Nassau County, with an expected household income of $47,754.00 as of December 17, 2017, and (2) assist you with your plan selection as of that date.

Decision

The December 17, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to (1) redetermine you and your spouse's eligibly for financial assistance based on a four-person household in Nassau County, with an expected household income of $47,754.00 as of December 17, 2017, and (2) assist you with your plan selection as of that date once you and your spouse eligibility has been determined.

Effective Date of this Decision: March 27, 2018

How this Decision Affects Your Eligibility

This is not your final determination. You will receive a new eligibility determination shortly, and NYSOH will assist with your plan enrollment as of December 17, 2017.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the Decision is final unless you submit an appeal request to the Federal Marketplace 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 Federal Marketplace. 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 have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061
- By fax: 1-877-369-0129

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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

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).

Summary

The December 17, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to (1) redetermine you and your spouse's eligibly for financial assistance based on a four-person household in Nassau County, with an expected household income of $47,754.00 as of December 17, 2017, and (2) assist you with your plan selection as of that date once you and your spouse eligibility has been determined.

This is not your final determination. You will receive a new eligibility determination shortly, and NYSOH will assist with your plan enrollment as of December 17, 2017.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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