



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

Notice of Decision

Decision Date: April 17, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013110

[REDACTED]

Dear [REDACTED]

On March 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 3, 2016 eligibility redetermination 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).

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NY State of Health Account ID: [REDACTED]
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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 (NYSOH) properly determine that you and your spouse were eligible to share in up to \$270.00 per month in advance payments of the premium tax credit (APTC) as of December 1, 2016?

Did NYSOH properly determine that you and your spouse were not eligible for the Essential Plan as of December 1, 2016?

Procedural History

On November 3, 2016, NYSOH issued an eligibility redetermination notice, based on the information contained in the November 2, 2016 application, stating that you and your spouse was eligible to share in APTC in an amount of up to \$270.00 per month, effective December 1, 2016.

On November 7, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility redetermination as it related to your and your spouse's financial assistance.

On March 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open until April 6, 2016 for you to submit proof of income. On March 25, 2017, you submitted your 2016 federal and state income tax returns. These documents were made part of the record as "Appellant's Exhibit A." No further documentation was received by April 6, 2016 and the record closed that day.

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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 no dependents on that tax return.
- 2) You are seeking insurance for you and your spouse.
- 3) The application that was submitted on November 2, 2016 listed annual household income of \$57,952.22, consisting of \$30,963.00 you earn from your employment and self-employment and \$26,989.22 your spouse receives in employment. You testified that you believe this amount is correct but you are not sure because you have not completed your taxes yet.
- 4) According to your application, you will be taking deductions from your income. These deductions include for you: \$3,000.00 in self-employment expenses, \$1,250.00 in industry research and \$2,000.00 in an IRA deduction; and for your spouse: \$1,250 in industry research. You testified that this was mostly correct, but that you had to check and that yours and your spouse's industry research deduction was closer to \$2,847.40 combined.
- 5) You testified that both your and your spouse's incomes have changed.
- 6) On March 25, 2017, you submitted proof of income that reflects that you and your spouse have a combined earned income of \$47,929.00, a combined business loss of \$67.00, and an unearned income of \$1,828.00 in 2016; for a total household income of \$49,690.00 (see [REDACTED]).
- 7) Your submitted 2016 income tax return also reflects that you have a \$46.00 business deduction for self-employment tax. An annual income of \$49,690.00 less your business expense deduction of \$46.00, equals an adjusted gross annual income of \$49,644.00 (see [REDACTED]).
- 8) You testified that your spouse needs to remain on the Essential Plan to see her specialists.
- 9) According to your application and your testimony, you and your spouse live in [REDACTED], New York.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

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Applicable Law and Regulations

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)).

Business Expenses Deduction

“Adjusted gross income” is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, deductions that are attributable to a trade or business may be deductions from a taxpayer’s adjusted gross income (26 USC § 62 (a)(1)).

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 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 \$ 15,930.00 for a two-person household (80 Federal Register 3236, 3237).

For annual household income in the range of at least 300% but less than 400% of the 2015 FPL, the expected contribution in 2016 is 9.66% 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).

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 application, that was the 2015 FPL, which is \$15,930.00 for a two-person household (80 Fed. Reg. 3236, 3237).

A person who has a household income that is at or below 150% of the FPL has a \$0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

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A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a \$20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (see 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your spouse were eligible to share in APTC of up to \$270.00 per month.

You and your spouse are in a two-person household for purposes of this analysis. This is because you expect to file your 2016 income taxes as married filing jointly and will claim no dependents on that tax return.

The application that was submitted on November 2, 2016 listed an annual household income of \$57,952.22, and NYSOH relied upon this information.

You and your spouse reside in [REDACTED], where the second lowest cost silver plan available for a couple through NYSOH costs \$736.52 per month.

An annual income of \$57,952.22 is 363.79% of the 2015 FPL for a two-person household. At 363.79% of the FPL, the expected contribution to the cost of the health insurance premium is 9.66% of income, or \$466.52 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 couple in your county (\$736.52 per month) minus your expected contribution (\$466.52 per month), which equals \$270.00 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to \$270.00 per month in APTC.

Since the November 3, 2016 eligibility redetermination notice properly stated that you and your spouse were eligible to share in an amount of up to \$270.00 APTC, based on the information obtained by NYSOH, it is correct and must be **AFFIRMED**.

However, on March 25, 2017, you submitted documentation that reflects that you and your spouse have an adjusted gross income of \$49,644.00 for 2016, which includes your combined earned incomes of \$47,929.00, a business loss of 67.00, an unearned income of \$1,828.00 in 2016, and a \$46.00 self-employment tax deduction (see [REDACTED]).

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Since the record now contains a more accurate representation of what your 2016 household annual income is, your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance as a couple residing in [REDACTED], in a two-person household with an expected household income of \$49,644.00.

The final issue is whether NYSOH properly determined that you and your spouse were ineligible for the Essential Plan as of December 1, 2016.

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 relevant FPL was \$15,930.00 for a two-person household. Since an annual household income of \$49,644.00 is 311.64% of the 2015 FPL, NYSOH properly found you and your spouse to be ineligible for the Essential Plan.

Decision

The November 3, 2016 eligibility redetermination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance as a couple residing in [REDACTED], in a two-person household with an expected household income of \$49,644.00, and to notify you accordingly.

Effective Date of this Decision: April 17, 2017

How this Decision Affects Your Eligibility

You and your spouse were properly determined to be eligible to share in APTC of up to \$270.00 per month, effective December 1, 2016.

You and your spouse were properly determined to be ineligible for the Essential Plan, effective December 1, 2016.

However, your case is sent back to NYSOH to redetermine your and your spouse's eligibility for financial assistance based on the evidence you presented at and after the hearing.

At present, your spouse has Essential Plan coverage as of December 1, 2016 as aid to continue during the appeal process, which will not be disturbed until your and her eligibility for financial assistance is redetermined by NYSOH. NYSOH will

notify you once this has been done and what further action may be required on your part, if applicable.

If You Disagree with this Decision (Appeal Rights)

This 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:

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).

- 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 November 3, 2016 eligibility redetermination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance as a couple residing in [REDACTED], in a two-person household with an expected household income of \$49,644.00, and to notify you accordingly.

You and your spouse were properly determined to be eligible to share in APTC of up to \$270.00 per month, effective December 1, 2016.

You and your spouse were properly determined to be ineligible for the Essential Plan, effective December 1, 2016.

However, your case is sent back to NYSOH to redetermine your and your spouse's eligibility for financial assistance based on the evidence you presented at and after the hearing.

At present, your spouse has Essential Plan coverage as of December 1, 2016 as aid to continue during the appeal process, which will not be disturbed until your and her eligibility for financial assistance is redetermined by NYSOH. NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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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