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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017246

[redacted]

Dear [redacted],

On July 19, 2017, you and your spouse appeared by telephone at a hearing on your appeal of NY State of Health's March 25, 2017 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017246

[redacted]

Issues

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

> Did NY State of Health properly determine you and your spouse were eligible to purchase a full cost qualified health plan, effective May 1, 2017?
>
> Did NY State of Health properly determine your children were eligible to enroll in a full cost Child Health Plus plan, effective May 1, 2017?

Procedural History

On March 24, 2017, NY State of Health (NYSOH) received the updated application for financial assistance with health insurance submitted on behalf of you and your family. That day, a preliminary eligibility determination was prepared stating you and your spouse were eligible to purchase a full cost qualified health plan (QHP), effective May 1, 2017. That determination also stated that your children were eligible to enroll in a full cost Child Health Plus plan.

Also on March 24, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as you and your family were not eligible for financial assistance with health insurance.

On March 25, 2017, NYSOH issued a notice of eligibility determination, based on the March 24, 2017 application, stating you and your spouse were eligible purchase a full cost QHP, effective May 1, 2017. That notice also stated your children were eligible to enroll in a full cost Child Health Plus plan. The notice indicated that you and your family were not eligible for financial assistance with

health insurance, because your household income was over the allowable income limit for all financial assistance programs.

On July 19, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents.

On August 3, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1. The record closed thereafter.

Findings of Fact

A review of the record supports the following findings of fact:

1) You submitted an application for financial assistance with health insurance on December 28, 2017 listing an annual household income of $89,480.00.

2) According to your account, NYSOH was unable to verify the income information listed in that application and you and your family were determined conditionally eligible for financial assistance pending receipt of income documentation to verify the information listed in your application.

3) On January 25, 2017, you submitted a signed copy of a Form 1040 from the 2015 joint tax return of you and your spouse.

4) According to your account, NYSOH verified your income documentation and increased your attested annual household income amount by $100,908.00 to include the amounts listed in the 2015 tax return for capital losses, IRA distributions, and additional income from "[redacted]" The adjusted household income calculated by NYSOH was $184,388.00.

5) Based on the recalculated household income, NYSOH determined you and your family were not eligible for financial assistance.

6) You testified that the 2015 tax return submitted was not accurate of your household income for 2017, because it included a $59,100.00 IRA distribution received in 2015 that you will not receive in 2017.

7) On March 24, 2017, you contacted NYSOH and an updated application for financial assistance was submitted on behalf of you and your family. That application listed your annual household income as $103,880.00 consisting of $53,600.00 you earn in business income and $50,280.00 your spouse earns in business income.

8) You testified the income amount listed in that application was accurate with regards to your anticipated income for 2017.

9) You spouse testified that the amount listed in the March 24, 2017 application for him was what he expected to make for the year at that time. Your spouse testified that he has actually made much less than the amount anticipated in March 2017 due to receiving less projects than he had projected.

10) Your spouse was directed to submit three months of detailed business records as proof of a change in his income for 2017. On August 3, 2017, NYSOH received the requested documentation including invoices for income received from February through July 2017 as well as a profit and loss statement for those months ([redacted]).

11) Based on the income information in the March 24, 2017 application, NYSOH determined you and your family were not eligible for financial assistance, because your attested annual household income was over the allowable amount for all financial assistance programs.

12) The March 24, 2017 application indicated you and your spouse would file your 2017 tax return with a tax filing status of married filing jointly and you would claim two dependents on that return. You testified that information was accurate.

13) You testified you are seeking advance payments of the premium tax credit (APTC) for you and your spouse and a subsidy for your children's Child Health Plus plan premiums.

14) According to your account, you and your family were grated Aid to Continue pending the outcome of your appeal.

15) According to your application, you and your family live in [redacted].

16) You testified, and your application indicates, you will not take any additional deductions not already included in your attested income amounts on your 2017 tax return.

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 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)).

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 Federal Register 4036).

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).

Child Health Plus

Child Health Plus (CHP) is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (*see* New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be “eligible for medical assistance”; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child’s family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL §

2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from $9.00 per month to $60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is $9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than $27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

The CHP premium is $15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than $54.00 per month per family (NY PHL § 2510(9)(d)(iii)).

The CHP premium is $30.00 per month for a child whose family household income is between 251% and 300% of the FPL, but no more than $90.00 per month per family (NY PHL § 2510(9)(d)(iv)).

The CHP premium is $45.00 per month for a child whose family household income is between 301% and 350% of the FPL, but no more than $135.00 per month per family (NY PHL § 2510(9)(d)(v)).

The CHP premium is $60.00 per month for a child whose family household income is between 351% and 400% of the FPL, but no more than $180.00 per child (NY PHL § 2510(9)(d)(vi)).

In an analysis of Child Health Plus eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which was $24,600.00 for a four-person household (80 Federal Register 3236, 3237).

Legal Analysis

The first issue under review is whether NYSOH properly determined you and your spouse were eligible to purchase a full cost QHP, effective May 1, 2017.

On March 24, 2017, you contacted NYSOH and an updated application for financial assistance was submitted on behalf of you and your family. That application listed your annual household income as $103,880.00 consisting of $53,600.00 you earn in business income and $50,280.00 your spouse earns in business income. You testified the income amount listed for you in that application was accurate. Your spouse testified that the income amount listed for him in that application was his best estimate, at that time, of the income he would earn for the year. Although your spouse testified that he has not earned as much income this year as he anticipated he would, the March 24, 2017 eligibility determination at issue relied upon the income information you provided in the March 24, 2017 application.

According to that application, you and your family 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.

Pursuant to the regulations, APTC are generally available to a person who is eligible to enroll in a 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.

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. On the date of your application, that was the 2016 FPL, which is which is $24,300.00 for a four-person household. The annual household income amount you provided in your March 24, 2017 application, $103,880.00, is 427.49% of the 2016 FPL for a four-person household. As APTC is only available to individuals who expect to have a household income less than 400% of the FPL, you and your spouse were not eligible to receive APTC to help pay for the cost of health coverage, based on the information you provided in the March 24, 2017 application.

The second issue under review is whether NYSOH properly determined your children were eligible to enroll in a full cost Child Health Plus plan, effective May 1, 2017.

As discussed above, you attested in your March 24, 2017 updated application that your annual expected household income was $103,880.00 and the eligibility determination at issue relied upon that information.

A child is eligible to enroll in Child Health Plus with a subsidy payment if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL.

On the date of your application, the relevant FPL was $24,600.00 for a four-person household. Since $103,880.00 is 422.28% of the 2017 FPL, NYSOH properly found your children ineligible to receive a subsidy payment to help pay for the cost of a Child Health Plus plan.

Since the March 25, 2017 eligibility determination properly stated that, based on the information you provided, you and your spouse were eligible to purchase a full cost QHP and not eligible to receive financial assistance, and your children were eligible to enroll in a full cost Child Health Plus plan, and ineligible for a subsidy, that determination was correct and is AFFIRMED.

It is noted that your spouse testified that while the income information included in the March 24, 2017 application was his best estimate of the income he would make in 2017 at the time of the application, that he has actually made much less due to receiving less projects than he had projected. On August 3, 2017, NYSOH received income documentation submitted on behalf of your spouse including invoices for income received from February through July 2017 as well as a profit and loss statement for those months. Therefore, your case is RETURNED to NYSOH to redetermine the eligibility of you and your family based on the updated income information received on August 3, 2017.

Decision

The March 25, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine the eligibility of you and your family from this point forward for financial assistance, based on the updated income information received on August 3, 2017.

Effective Date of this Decision: August 24, 2017

How this Decision Affects Your Eligibility

You and your spouse remain eligible to purchase a full cost QHP.

Your children remain eligible to enroll in a full cost Child Health Plus plan or child-only QHP.

You and your family are not eligible to receive financial assistance, based on the March 24, 2017 application.

Your case is being sent back to NYSOH to redeterined the eligibility of you and your family to receive financial assistance, going forward, based on the updated income information uploaded to your account on August 3, 2017

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:

- 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 March 25, 2017 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).

Your case is RETURNED to NYSOH to redetermine the eligibility of you and your family for financial assistance based on the updated income information received on August 3, 2017.

You and your spouse remain eligible to purchase a full cost QHP.

Your children remain eligible to enroll in a full cost Child Health Plus plan or child-only QHP.

You and your family are not eligible to receive financial assistance, based on the March 24, 2017 application.

Your case is being sent back to NYSOH to redeterined the eligibility of you and your family to receive financial assistance, going forward, based on the updated income information uploaded to your account on August 3, 2017

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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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।

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).

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 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 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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