



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

### **Notice of Decision**

Decision Date: May 7, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000026919



Dear [REDACTED] and [REDACTED]

On April 9, 2018, you both appeared by telephone at a hearing on the appeal of NY State of Health's December 29, 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  
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.

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## Decision

Decision Date: May 7, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000026919



## 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 were eligible to receive up to \$263.00 per month in advance payments of the premium tax credit, effective February 1, 2018?

Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?

Did NY State of Health properly determine that you were not eligible for the Essential Plan?

Did NY State of Health properly determine that you were not eligible for Medicaid?

## Procedural History

According to your NY State of Health (NYSOH) account, pursuant to NYSOH's request, you submitted proof of income on November 17, 2017, December 5, 2017 and December 27, 2017 (see Documents [REDACTED])

[REDACTED] These documents were all validated by NYSOH as sufficient proof of income.



On December 29, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$263.00 in APTC, effective February 1, 2018. That notice also stated that you were not eligible for cost-sharing reductions, the Essential Plan, or Medicaid because your income was over the allowable income limits for those programs.

On January 8, 2018 you spoke to NYSOH's Account Review Unit and appealed the amount of your financial assistance.

On April 9, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your authorized representative appeared and testified also. The record was developed during the hearing and held open to April 26, 2018, to allow you time to submit supporting documents.

On April 20, 2018, you submitted additional proof of income. These documents were made part of the record as "Appellant's Exhibit A." The record closed that day.

## Findings of Fact

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

- 1) According to your NYSOH account and testimony, you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.
- 2) According to your NYSOH account, at all times relevant, you were [REDACTED]
- 3) You are seeking health insurance for yourself.
- 4) The application that was submitted on December 29, 2017 listed annual household income of \$33,359.00, consisting of \$14,014.00 you earn from your employment, plus \$21,987.00 you receive in capital gains income, \$1,896.00 you receive in ordinary dividends, and \$3.00 you receive in taxable interest less \$541.00 in student loan interest and \$4,000.00 in tuition and fees deductions. This income was based on the income documentation you submitted (see Documents [REDACTED]). Your authorized representative testified that this amount was incorrect.
- 5) Your authorized representative further testified that your dividends and capital gains income should not be calculated in determining your eligibility because you receive dividends from stocks that were rolled over into

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another account (and never actually received as income) and that the capital gains income was a one-time payout that you will not receive again.

- 6) You testified, and submitted documentation to show, that you expect to have \$23,962.00 in modified adjusted gross income, consisting of \$17,019.00 in earned income in 2018, calculated as follows:
- a) Employment income of \$300.00 per week for 24 weeks from January 1, 2018 through June 16, 2018 (\$7,200.00);
  - b) Employment income of \$600.00 per week for 6 weeks in the summer (\$3,600.00); and,
  - c) Employment income of \$300.00 per week for 16 weeks from September 15, 2018 through December 31, 2018 (\$4,800.00);
  - d) Self-employment income of \$1,419.00;
  - e) Taxable dividends of \$3,566.00; and
  - f) Capital gains of \$3,726.00;
  - g) Less a student loan interest deduction of \$249.00 and a business expense deduction of \$100.00

(see Document [REDACTED] and Appellant's Exhibit A, [REDACTED]).

- 7) You submitted documentation that shows your income for December 2017 was \$7,705.36, consisting of:
- a) Employment income of \$1,560.00, from three consecutive bi-weekly paystubs, dated December 1, 2017 through December 29, 2017;
  - b) A withdrawal from your brokerage account of \$4,600.00, including a \$3,000.00 distribution rolled over into a Roth IRA;
  - c) Taxable dividends of \$972.29;
  - d) Capital gains of \$933.80 in capital gains; and
  - e) Interest of \$1.66;
  - f) Less \$333.33 in tuition and fees deductions (\$4,000.00 year/12 months); \$20.73 in student loan interest (\$248.73 year/12 months); and, \$8.33 business expense deduction (\$100.00 year/12 months)

(see Appellant's Exhibit A, [REDACTED] and [REDACTED]).

- 8) Your application states that you live in [REDACTED], New York.

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)).

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 December 28, 2017 application, that was the 2017 FPL, which is \$12,060.00 for a one-person household (82 Federal Register 8831).

For annual household income in the range of at least 250% but less than 300 % of the 2017 FPL, the expected contribution is between 8.10% and 9.56 % 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

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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)).

### 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 2017 FPL, which is \$12,060.00 for a one-person household (82 Fed. Reg. 8831).

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)).

### Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

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In an analysis of Medicaid 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 is \$12,060.00 for a one-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

### Gross Income

Gross Income is defined as all income from whatever source derived, including but not limited to compensation, business income, interest, dividends, annuities, alimony, pensions, life insurance income, and income from an estate or trust (see 26 USC § 61).

### 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 federal taxable 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)).

### Individual Retirement Accounts

Generally, gross income does not include distribution that is rolled over into a tax-deferred IRA account within 60 days of that distribution. However, gross income does include any and all contributions made to a “Roth IRA” or any other IRA in which the contributions are taxable, or the distributions are not-taxable (see 26 USC § 408A (d)(1); *and* see 26 USC § 408 (b)(1); and (3); also 26 USC § 3405 (2)(ii)).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to \$263.00 per month.

The application that was submitted on December 28, 2017, listed an annual household income of \$33,359.00 and the eligibility determination relied upon that information. Although, you testified that this amount was incorrect, based upon



the information you submitted at the time, including your 2016 income tax return, NYSOH properly determined your income to be \$33,359.00.

According to your NYSOH account and testimony, you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return. Therefore, for purposes of these analyses, you are in a one-person household.

You reside in Queens County, where the second lowest cost silver plan available for an individual through NYSOH costs \$509.30 per month.

An annual income of \$33,359.00 is 276.61% of the 2017 FPL for a one-person household. At 276.61% of the FPL, the expected contribution to the cost of the health insurance premium is 8.87% of income, or \$246.58 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 (\$509.30 per month) minus your expected contribution (\$246.58 per month), which equals \$262.72 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$263.00 per month in APTC, based on the information you provided.

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 \$33,359.00 is 276.61% of the applicable FPL, NYSOH properly found you to be ineligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan, effective February 1, 2018.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$12,060.00 for a one-person household. Since an annual household income of \$33,359.00 is 276.61% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, you were [REDACTED] and the relevant FPL was \$12,060.00 for a one-person household. Since \$33,359.00 is

276.61% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted three bi-weekly paystubs, dated December 1, 2017 through December 29, 2017; a brokerage account statement for the period of December 1, 2017 through December 31, 2017; and your 2017 Income tax return that shows, in December 2017, you received at least \$4,705.36 in gross monthly household income.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,367.00 per month. Since the documentation you provided shows that you received \$7,705.36 in December 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the December 29, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$263.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid, it is correct and is AFFIRMED.

However, since the record now contains a more accurate representation of your 2017 expected modified adjusted gross annual household income of \$23,962.00, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2018, based on a modified adjusted gross annual household income of \$23,962.00 per year, and a household size of one, for an individual residing in [REDACTED], New York.

## **Decision**

The December 29, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2018, based on a modified adjusted gross annual household income of \$23,962.00 per year, and a household size of one, for an individual residing in [REDACTED], New York.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

**Effective Date of this Decision:** May 7, 2018

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

This is not a final determination of your eligibility for financial assistance in 2018.

While your eligibility for financial assistance was based on your submitted proof of income and, therefore, was correct as of your December 28, 2017 application, your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2018 based on the most current income information and other factors as noted above.

## **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

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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 29, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2018, based on a modified adjusted gross annual household income of \$23,962.00 per year, and a household size of one, for an individual residing in [REDACTED], New York.

This is not a final determination of your eligibility for financial assistance in 2018.

While your eligibility for financial assistance was based on your submitted proof of income and, therefore, was correct as of your December 28, 2017 application, your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2018 based on the most current income information and other factors as noted above.

NYSOH is directed to notify you of its redetermination 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. y&b&tumi ama wo obi a okyer& 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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