



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

## Notice of Decision

Decision Date: April 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013758

[REDACTED]

Dear [REDACTED],

On March 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 3, 2016 eligibility determination.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

### Legal Authority

We are sending you this notice in accordance with Federal regulation 45 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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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: April 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013758



## Issue

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

Did New York State of Health (NYSOH) properly determine that you were not eligible to enroll in the Essential Plan as of December 3, 2016?

## Procedural History

On December 2, 2016, you submitted an application for financial assistance through NYSOH. Based on that application, NYSOH rendered a preliminary eligibility determination that you were temporarily eligible to enroll in a qualified health plan with a maximum monthly tax credit of \$254.00. Furthermore, you were directed to submit additional documentation to confirm the information that you provided in your application was accurate.

Also on December 2, 2016, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as your eligibility to enroll in the Essential Plan.

On December 3, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for up to \$254.00 of advance premium tax credit (APTC) per month for a limited time, effective as of January 1, 2017. The notice also stated that you were not eligible for coverage through the Essential Plan.

On December 10, 2016, NYSOH issued an eligibility determination notice stating that you have been granted Aid to Continue until a decision has been made on your appeal. The notice states that you were eligible for the Essential Plan for a limited time, with a monthly premium of \$20.00, effective January 1, 2017.

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On March 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until March 28, 2017 to allow you to submit documentation to indicate whether you would be claiming a dependent on your 2017 federal income tax return.

On March 28, 2017, you faxed two-pages of documents to NYSOH Appeals Unit. That fax will be referred to as "Appellant Exhibit A" and has been incorporated into the record. The record is now complete and closed.

## **Findings of Fact**

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

1. According to your NYSOH account and testimony, you are applying for health insurance through NYSOH for yourself.
2. According to your NYSOH account, you expect to file a 2017 federal income tax return, with the tax status of Head of Household (with qualifying individual), and do not expect to claim any dependents on that tax return.
3. You testified that you did not know if you were going to claim your child as a dependent on your 2017 federal income tax return.
4. According to your NYSOH account and testimony, you expect to receive \$30,000.00 in alimony in 2017.
5. According to your NYSOH account, you reside in [REDACTED] County, New York.
6. On March 28, 2017, you submitted a letter stating that you would not be claiming your child as a dependent on your 2017 federal income tax return (Appellant Exhibit A pg. 2).

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

## **Applicable Law and Regulations**

### Household Size

For the purposes of determining an individual's eligibility for the Essential Plan, an individual's household size equals the individuals for whom a taxpayer properly claims a deduction for a personal exemption under 26 USC § 151 for the taxable year (42 CFR § 435.600.5; 26 CFR 1.36B-1(d)).

### 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 2016 FPL, which is \$11,880.00 for a one-person household (81 Fed. Reg. 4036).

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>).

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).

### **Legal Analysis**

The issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan as of December 3, 2016.

According to your December 2, 2016 application, you expect to file your 2017 federal tax return, with the tax status of Head of Household (with qualifying individual), and do not expect to claim any dependent on that return. Therefore, you are in a one-person household.

Furthermore, in that application, you attested to an annual household income of \$30,000.00 and the eligibility determination issued on December 3, 2016 relied on that information.

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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. Furthermore, 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

On the date of your application, the relevant FPL was \$11,880.00 for a one-person household. Since \$30,000.00 is 252.52% of the 2016 FPL, NYSOH properly found you to be not eligible to enroll in the Essential Plan.

Therefore, the December 3, 2016 eligibility determination is AFFIRMED.

However, during the hearing you testified that you did not know if you would be claiming your child as a dependent on your 2017 federal income tax return. The record was left open until March 28, 2017, to allow you the opportunity to submit documentation to indicate if you would be claiming your child as a dependent on your 2017 federal income tax return.

On March 28, 2017, you submitted a letter to NYSOH Appeals Unit stating that you would not be claiming your child as a dependent on your tax return. Therefore, your case will not be returned to NYSOH to recalculate your eligibility for financial assistance.

## **Decision**

The December 3, 2016 eligibility determination is AFFIRMED.

**Effective Date of this Decision:** April 10, 2017

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

NYSOH properly determined that you were not eligible to enroll in the Essential Plan as of December 3, 2016.

## **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

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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 December 3, 2016 eligibility determination is **AFFIRMED**.

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NYSOH properly determined that you were not eligible to enroll in the Essential Plan as of December 3, 2016.

### **Legal Authority**

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).



**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)**

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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।

### **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.

### **אַײַדיש (Yiddish)**

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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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