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

Notice of Decision

Decision Date: July 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017827

[redacted]

Dear [redacted]

On July 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 22, 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.

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: July 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017827

[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 were ineligible to receive financial assistance as of March 22, 2017?

Procedural History

On March 4, 2017, you submitted an application for financial assistance through NYSOH.

On March 5, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, with a $20.00 premium per month for a limited time, effective as of April 1, 2017. The notice directed you to submit additional proof of income by June 2, 2017, to confirm your eligibility. The notice provided a list of acceptable documentation to confirm your income.

Also on March 5, 2017, NYSOH issued a plan enrollment notice confirming that as of March 4, 2017, you were enrolled in an Essential Plan with an enrollment start date of April 1, 2017.

On March 10, 2017, additional income documentation was uploaded to your NYSOH account (see Document [redacted]

On March 21, 2017, your NYSOH account was updated.

On March 22, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost, effective May 1, 2017. The notice stated, in relevant part, that you did not qualify for the Essential Plan or to receive a tax credit because the income in your application was over the maximum allowable income limit for these programs.

On March 22, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end on April 30, 2017, because you were no longer eligible to enroll in the Essential Plan.

On April 6, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as you were determined ineligible to receive financial assistance through NYSOH.

On April 22, 2017, NYSOH issued a notice stating that you were eligible for the Essential Plan for a limited time with a $20.00 premium per month, effective as of May 1, 2017. The notice stated that you have been granted Aid to Continue until a decision is made on your appeal.

On July 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 proceeding.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are seeking insurance for yourself.

2) According to your NYSOH account and testimony, you expect to file a 2017 federal income tax return with the tax status of single. You do not expect to claim any dependents on that return.

3) According to your March 4, 2017 application, you are self-employed and attested to a 2017 expected income of $21,828.00.

4) You faxed your 2016 Form 1040 U.S. Individual Income Tax Return to NYSOH. According to Line 37 of that return, your adjusted gross income in 2016 was $79,320.00 (see Document [redacted]

5)

6) You testified that your 2016 federal income tax return does not accurately represent your income in 2017 because of your gambling winnings in 2016. You expect the income and deductions on your 2016 federal income tax return to be similar, with the exception of the gambling winnings.

7) According to Line 21 of your 2016 Form 1040 U.S. Individual Income Tax Return, your [redacted] were $50,307.00 (see Document [redacted]
8)
9) You testified that you reside in [redacted], New York.

10) You testified that you want to be found eligible to enroll in the Essential Plan.

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

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)).

"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)).

"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)).

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 $11,880.00 for a one-person household (81 Federal Register 4036).

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).

Income Verification Process

For all individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow the NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f); 42 CFR §600.345 (a)) See also New York's Basic Health Plan Blueprint, p. 17, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were ineligible to receive financial assistance as of March 22, 2017.

On March 4, 2017, you submitted an application through NYSOH. In that application, you attested that you were self-employed and that your 2017 expected income was $21,828.00.

For all individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

The income information that was entered into this application did not match information from federal and state data sources. As a result, on March 5, 2017 NYSOH issued a notice directing you to submit additional income documentation to confirm your eligibility. The notice issued by NYSOH directed you to submit additional documentation that included a list of acceptable documentation, including a filed tax return from the previous year if representative of attested income (*see* Document [redacted]).

On March 10, 2017, your 2016 Form 1040 U.S. Individual Income Tax Return was uploaded to your NYSOH account. According to that return, your adjusted gross income in 2016 was $79,320.00 (see Document [redacted]. Based on the documentation submitted, NYSOH recalculated your expected household income.

You testified that you expected to file a 2017 federal income tax return using with the tax status of single, and did not expect to claim any dependents on that tax return. Therefore, you are in a one-person household. An annual income of $79,320.00 is 667.68% of the 2016 FPL for a one-person household.

APTC is available to a person who has a household income no greater than 400% of the FPL. Further, an individual is eligible to enroll in an Essential Plan if their household income does not exceed $200% of the FPL. Based on the documentation provided to NYSOH, your household income was $79,320.00, which is 667.68% of the 2016 FPL for a one-person household. Therefore, NYSOH correctly found you to be ineligible for financial assistance through NYSOH.

Therefore, the March 22, 2017 eligibility determination notice is AFFIRMED.

During the hearing, you testified that your 2016 federal income tax return does not accurately represent your income in 2017 because of your [redacted] in 2016. You expect the income and deductions listed in your 2016 federal income tax return to be similar in 2017, with the exception of the [redacted] According to Line 21 of your 2016 Form 1040 U.S. Individual Income Tax Return, your [redacted] were $50,307.00. Therefore, your 2017 expected household income is $29,013.00 ($79,320.00 - $50,307.00).

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household for an individual living in [redacted], New York, with an expected household of $29,013.00.

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).

Decision:

The March 22, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household for an individual living in [redacted], New York, with an expected household of $29,013.00, and to notify you accordingly.

Effective Date of this Decision: July 27, 2017

How this Decision Affects Your Eligibility

You remain ineligible for APTC and the Essential Plan.

Your case has been sent back to NYSOH to recalculate your eligibility for financial assistance based on the criteria noted above. NYSOH will notify you of its redetermination.

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 22, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household for an individual living in [redacted], New York, with an expected household of $29,013.00, and to notify you accordingly.

You remain ineligible for APTC and the Essential Plan.

Your case has been sent back to NYSOH to recalculate your eligibility for financial assistance based on the criteria noted above. NYSOH will notify you of its redetermination.

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]

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 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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