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

Notice of Decision

Decision Date: November 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021836

[redacted]

Dear [redacted],

On October 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 19, 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: November 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000021836

[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 for the Essential Plan?

Procedural History

On May 22, 2017, you submitted an application for financial assistance through NYSOH.

On May 23, 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 July 1, 2017. The notice directed you to provide proof of income by August 20, 2017, to confirm your eligibility.

Also on May 23, 2017, NYSOH issued a plan enrollment notice confirming that as of May 22, 2017, you were enrolled in an Essential Plan with an enrollment start date of July 1, 2017. The notice directed you to provide proof of income by August 20, 2017, to confirm your eligibility.

On August 14, 2017, you mailed additional income documentation to NYSOH (*see* Documents [redacted] uploaded 8/17/2017).

On August 18, 2017, your NYSOH account was updated.

On August 19, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for a tax credit up to $330.00 per month and cost-sharing reductions, effective as of October 1, 2017, based on an expected annual income of $24,955.45. Further, you were ineligible for the Essential Plan because your household income exceeded the income threshold for that program.

Also on August 19, 2017, NYSOH issued a disenrollment notice stating that you were no longer eligible for the Essential Plan as of September 30, 2017.

On August 25, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance you were determined eligible to receive.

On August 26, 2017, NYSOH issued a plan enrollment notice confirming that as of August 25, 2017, you were enrolled in a QHP with an enrollment start date of October 1, 2017.

On August 29, 2017, your NYSOH account was systemically updated.

On August 30, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a $20.00 premium for a limited time, effective as of October 1, 2017. You had been granted Aid to Continue until a decision was made on your appeal.

Also on August 30, 2017, NYSOH issued an enrollment notice confirming that as of August 29, 2017, you were enrolled in an Essential Plan with an enrollment start date of October 1, 2017.

On October 24, 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 October 31, 2017, to allow you to submit your 2016 federal income tax return.

On October 28, 2017, you submitted three-pages of documentation to NYSOH Appeals Unit. That documentation was made part of the record as "Appellant Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) You testified that you are only appealing the amount of financial assistance you were determined eligible to receive.

2) According to your NYSOH account and testimony, you are employed at [redacted] and [redacted].

3) On August 14, 2017, you submitted the following earnings statements:

(a) [redacted] issued you federal taxable gross income of:

(i) $152.59 on July 07, 2017;
(ii) $209.79 on July 14, 2017;
(iii) $145.91 on July 21, 2017;
(iv) $201.00 on July 28, 2017;

(b) [redacted] issued you federal taxable gross income of:

(i) $293.43 on July 05, 2017;
(ii) $312.93 on July 12, 2017;
(iii) $311.66 on July 19, 2017;
(iv) $313.63 on July 26, 2017;

(*see* Documents [redacted]

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

5) According to your NYSOH account, you do not expect to claim any deductions on your 2017 federal income tax return.

6) According to your NYSOH account, you reside in [redacted], New York.

7) You testified that your income was inconsistent this year but expected your income to be the same as last year.

8) You testified that you are unable to afford the health insurance premiums based on the amount of financial assistance you were redetermined eligible to receive.

9) On October 28, 2017, you submitted your 2016 Form 1040A U.S. Individual Income Tax Return. According to Line 21 of your return, your 2016 adjusted gross income was $23,322.00.

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)). 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)).

"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)).

Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (26 USC § 262(a)).

Household Composition

For APTC, CSR and the Essential Plan, the household size equals the number of individuals for whom the taxpayers are allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(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 2016 FPL, which is $11,880.00 for a one-person household (81 Federal Register 4036).

Verification of Eligibility - Income

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 issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan as of August 19, 2017, with coverage to end September 30, 2017.

On May 22, 2017, you submitted a financial assistance application through NYSOH. Based on that application, NYSOH issued notices stating that you were eligible to enroll in the Essential Plan for a limited time. The notices instructed you to provide additional proof of your income by August 20, 2017, and provided a list of acceptable documentation.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to their household's projected annual income. For individuals seeking financial assistance, NYSOH must request income data from federal data sources to verify an individual's income attestation. If NYSOH cannot verify an individual's attestation, it must provide the individual with notice of the inconsistency and provide a period of 90 days from the date notice is received to resolve the inconsistency.

The record reflects that on August 14, 2017, you submitted to NYSOH your four most recent weekly earnings statements from your employers, [redacted] and [redacted]. Based on the documentation submitted, your annual household should have been calculated to be ($152.59 + $209.79 + $145.91 + $201.00 + $293.43 + $312.93 + $311.66 + $313.63 X 13 periods) $25,232.22.

For an individual who expects to file a federal income tax return, the household equals the taxpayers and the number of individuals for whom the taxpayer is claiming as a dependent.

You attested that you expect to file a 2017 federal income tax return with the tax status of single and did not expect to claim any dependents on that return. Therefore, you were in a one-person household.

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 $11,880.00 for a one-person household. Since an annual household income of $24, 955.45 is 210.06% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan on August 18, 2017.

The August 19, 2017 eligibility determination properly stated that, based on the information you provided, you were ineligible for the Essential Plan. Therefore, it is correct and AFFIRMED in relevant part.

Similarly, an annual household income of $25,232.22, as based on your earning statement submissions from your two employments, is 212.39% of the 2016 FPL, you would not be eligible for the Essential Plan based on this income, either.

However, you testified that your income was inconsistent and expected your income to be the same as last year. Therefore, you were instructed to provide your 2016 federal income tax return to NYSOH Appeals Unit.

On October 28, 2017, you submitted your 2016 Form 1040A U.S. Individual Income Tax Return. According to Line 21 of your return, your 2016 adjusted gross income was $23,322.00.

Therefore, 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], NY, with a 2017 household income of $23,322.00.

Decision

The August 19, 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], NY, with a 2017 household income of $23,322.00, and to notify you accordingly.

Effective Date of this Decision: November 7, 2017

How this Decision Affects Your Eligibility

You were properly determined ineligible for the Essential Plan as of August 18, 2017, as stated in the August 19, 2017 eligibility determination notice.

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 August 19, 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], NY, with a 2017 household income of $23,322.00, and to notify you accordingly.

You were properly determined ineligible for the Essential Plan as of August 19, 2017.

You were properly determined ineligible for the Essential Plan as of August 18, 2017, as stated in the August 19, 2017 eligibility determination notice.

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.

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).

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।

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 नि:शुल्क 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.

(Urdu)اردو

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.

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(Yiddish) אידיש

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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