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

Notice of Decision

Decision Date: November 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022377

[redacted]

Dear [redacted],

On November 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 9, 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 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022377

[redacted]

Issue

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

> Did NY State of Health properly determine that you were eligible to purchase a qualified health plan at full cost, effective October 1, 2017?

Procedural History

On August 18, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance.

On August 19, 2017, NYSOH issued a notice stating that the information listed in your application did not match what NYSOH received from state and federal data sources, and more information as needed to confirm the information in your application. This notice directed you to submit income documentation by September 2, 2017.

On August 28, 2017, you faxed a four-page document to NYSOH; which was uploaded to your NYSOH on September 6, 2017.

On September 8, 2017, NYSOH validated the documentation you faxed on August 28, 2017, and updated the income information in your account.

On September 9, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective October 1, 2017.

On September 13, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not found eligible for any financial assistance.

On September 14, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a full pay qualified health plan, effective October 1, 2017.

On October 25, 2017, NYSOH issued an eligibility determination stating that you were found eligible to enroll in the Essential Plan for a limited time, effective September 1, 2017, because you had been granted Aid to Continue until a decision was made on your appeal.

Also on October 25, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan, effective September 1, 2017.

On October 26, 2017, NYSOH issued a plan disenrollment notice confirming your disenrollment from the Essential Plan, effective November 30, 2017, because you asked NYSOH to end your coverage.

On November 15, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was closed at the end of the proceeding.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking health insurance for yourself.

3) The application that was submitted on September 8, 2017 listed annual household income of $53,091.27, consisting of $28,027.34 you earned from your employment, $12.00 you receive in taxable interest, $5,188.00 you receive in ordinary dividends, $1,863.93 you receive in qualified dividends, and $18,000.00 you receive in other income.

4) You testified, and provided documentation, that you stopped working on July 7, 2017.

5) You testified, and provided documentation, that you earned $28,027.34 from your employment between January 1, 2017 and July 7, 2017.

6) You testified that your only source of income thereafter is from dividends and other income from investments.

7) You provided your 2016 federal tax return which indicates that in 2016 you received $12.00 in taxable interest, $5,188.00 in ordinary dividends, $5,266.00 in capital gain, and $2,511.00 in other income.

8) You testified that the amount you received from taxable interest, ordinary dividends, capital gains, and other income should remain relatively the same in 2017 as they were in 2016.

9) Your application states that you will not be taking any deductions on your 2017 tax return.

10) Your application states that you live in Monroe County, New York.

11) You testified that you would like to be found eligible for some sort of financial assistance.

12) You testified that you believe NYSOH did not accurately calculate your expected annual income for 2017.

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)).

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible to purchase a qualified health plan at full cost, effective October 1, 2017.

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

On September 8, 2017, NYSOH validated the income documentation you submitted on August 28, 2017, as satisfactory documentation of your income and an application for financial assistance was run on your behalf. The NYSOH representative entered into your application an earned income of $28,027.34, ordinary dividends of $5,188.00, qualified dividends of $1,863.93, taxable interest of $12.00, and other income of $18,000.00. This resulted in an annual household income of $53,091.33.

However, NYSOH bases its eligibility determinations on modified adjusted gross income, which is adjusted gross income increased by any income that was excluded for United States citizens or residents living abroad, tax-exempt interest received or accrued, and Social Security benefits that were excluded from gross income. Adjusted gross income means gross federal taxable income minus certain deductions.

You testified, and submitted documentation, that you stopped working on July 7, 2017 and earned a gross annual income of $28,027.34 from this employment. You further testified that you receive income from dividends, and other investments. You submitted your 2016 federal tax return which indicate that, in 2016, you received a total of $12.00 in taxable income, $5,188.00 in ordinary dividends, $5,266.00 in capital gain, and $2,511.00 in other income. You further testified that this will be indicative of what you will receive from these sources in 2017. Therefore, your expected annual household income for 2017 is $41,004.34.

As a result, the September 8, 2017 application was erroneously submitted to include other income in the amount of $18,000.00. The application should have

only included the income that you had already listed from your employment, and the amount you received from dividends and other income, which are also listed in your 2016 tax return.

Since the September 9, 2017 eligibility determination notice is not supported by the documentation you provided as well as your credible testimony during the hearing, it is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of September 8, 2017, based on a one-person household, with an expected annual income of $41,004.34, for an individual residing in Monroe County, and to notify you accordingly.

Decision

The August 9, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility, as of August 8, 2017, based on a one-person household, with an expected annual income of $41,004.34, for an individual residing in Monroe County, and to notify you accordingly.

Effective Date of this Decision: November 27, 2017

How this Decision Affects Your Eligibility

This is not a final decision on your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility, as of August 8, 2017, based on the factors 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.

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).

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 9, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility, as of August 8, 2017, based on a one-person household, with an expected annual income of $41,004.34, for an individual residing in Monroe County, and to notify you accordingly.

This is not a final decision on your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility, as of August 8, 2017, based on the factors 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।

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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.

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.

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).