



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

Notice of Decision

Decision Date: May 21, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027324



Dear [REDACTED]

On April 27, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 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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Decision

Decision Date: May 21, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027324



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 no longer eligible for financial assistance as of December 9, 2017?

Procedural History

On December 6, 2017, you submitted an application for financial assistance through NYSOH.

On December 7, 2017, NYSOH issued two notices:

- (1) An eligibility determination notice stating that you were eligible for the advance payment of the premium tax credit (APTC) up to \$332.00 per month and cost-sharing reductions (CSR) for a limited time, effective January 1, 2018. The notice instructed you to submit proof of income by March 6, 2018, to confirm your eligibility.
- (2) A plan enrollment notice confirming that as of December 6, 2017, you were enrolled in a qualified health plan (QHP) with an enrollment start date of January 1, 2018. The notice instructed you to submit proof of income by March 6, 2018, to confirm your eligibility.

Also on December 7, 2017, you faxed additional income documentation to NYSOH (see Document [REDACTED] uploaded 12/08/2017).

On December 8, 2017, your NYSOH account was updated.

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On December 9, 2017, NYOSH issued an eligibility determination notice stating that you were newly eligible to purchase a QHP at full cost, effective January 1, 2018. Further, you were ineligible for financial assistance because your household income was over the allowable income limits for all insurance affordability programs.


On January 17, 2018, you spoke with NYSOH's Account Review Unit and requested an appeal because you were determined ineligible for financial assistance.

On March 30, 2018, you had a scheduled telephone hearing with NYSOH's Appeals Unit. You contacted NYSOH and requested that your telephone hearing be rescheduled, and that request was granted.

On April 27, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was closed at the end of the hearing.

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 for yourself.
- 2) According to your NYSOH account, you were enrolled in QHPs at full cost for the months of January 2018, February 2018, and March 2018.
- 3) According to your NYSOH account and testimony, you expect to file a 2018 federal income tax return with the tax status of single, and did not expect to claim any dependents on that tax return.
- 4) According to your December 6, 2017 application, you attested to an expected income of \$32,692.00 and deductions of \$4,458.00. Based on your attestations, your annual household income was calculated to be \$28,234.00.
- 5) On December 7, 2017, you submitted your 2016 Form 1040 U.S. Individual Income Tax Return to NYSOH. Line 37 of that return reflects that your adjusted gross income was \$39,409.00 in 2016 (see Document )
- 6) According to your NYSOH account, on December 8, 2017, NYSOH calculated your expected yearly income to be \$78,818.00.

- 7) According to your NYSOH account, you reside 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

Income Verification

An applicant is required to attest to their household's projected annual income for purposes of determining their eligibility for APTC (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

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 funds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

Household Composition

For APTC and CSR, 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)).

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Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible for financial assistance as of December 9, 2017.

On December 6, 2017, you applied for financial assistance through NYSOH. In that application you attested to an expected annual household income of \$28,234.00. Based on that application, NYSOH issued a notice stating that you were eligible for APTC up to \$332.00 per month and CSR for a limited time, effective January 1, 2018.

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. 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 notice issued on December 7, 2017, advised you that your eligibility was only conditional and that you needed to submit documentation to confirm your household's income by March 6, 2018.

The record reflects that, on December 7, 2017, you submitted your 2016 Form 1040 U.S. Individual Income Tax Return to NYSOH. Line 37 of that return reflects that your adjusted gross income was \$39,409.00 in 2016 (see Document [REDACTED]). Based on the documentation submitted, on December 8, 2017, NYSOH calculated your expected yearly income to be \$78,818.00.

The available record supports that NYSOH miscalculated your annual income by doubling the adjusted gross income that was stated your 2016 federal income tax return to \$78,818.00 (\$39,409.00 X 2). Based on this miscalculation, NYSOH issued the December 9, 2017 eligibility determination notice stating that you were ineligible for financial assistance because your household income was over the allowable income limits for all insurance affordability programs.

Therefore, the December 9, 2017 eligibility determination notice is RESCINDED.

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 2018 federal income tax return with the tax status of single, and did not expect to claim any dependents on that tax return. Therefore, you were in a one-person household. Further, your account reflects that you reside in [REDACTED] New York.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance as of December 9, 2017 for the months of January 2018, February 2018, and March 2018 and, if applicable prospectively, using a one-person household, for an individual living in [REDACTED], New York, with an expected annual household income of \$39,409.00.

Decision

The December 9, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to calculate your eligibility for financial assistance as of December 9, 2017 [REDACTED] for the months of January 2018, February 2018, and March 2018 and, if applicable prospectively, using a one-person household, for an individual living in [REDACTED], New York, with an expected annual household income of \$39,409.00, and to notify you accordingly.

Effective Date of this Decision: May 21, 2018

How this Decision Affects Your Eligibility

Your case has been returned to NYSOH to recalculate your eligibility for financial assistance based on the parameters 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

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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 9, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to calculate your eligibility for financial assistance as of December 9, 2017 [REDACTED] for the months of January 2018, February 2018, and March 2018 and, if applicable prospectively, using a one-person household, for an individual living in [REDACTED], New York, with an expected annual household income of \$39,409.00, and to notify you accordingly.

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Your case has been returned to NYSOH to recalculate your eligibility for financial assistance based on the parameters 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:



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 मदद 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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