



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
PO Box 11729  
Albany, NY 12211

## Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000028111



Dear [REDACTED]

On March 19, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 1, 2018 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  
PO 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(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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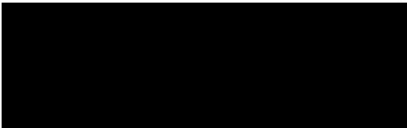


STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
PO Box 11729  
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## Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000028111



## Issue

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

Did NY State of Health (NYSOH) properly determine you were conditionally eligible to receive up to \$475.00 in advance payments of the premium tax credit, and ineligible for the Essential Plan, effective March 1, 2018?

## Procedural History

On January 31, 2018, NYSOH received two updated applications for financial assistance with your health insurance submitted on your behalf. That day a preliminary eligibility determination was created finding you conditionally eligible to receive up to \$475.00 in advance payments of the premium tax credit (APTC).

Also on January 31, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar as you were no longer eligible for the Essential Plan.

On February 1, 2018, NYSOH issued an eligibility determination notice stating you were eligible to receive up to \$475.00 in APTC, for a limited time, effective March 1, 2018. The notice stated you were also conditionally eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan. The notice further indicated you were not eligible for Medicaid, because the household income amount you provided was over the allowable income limit for that program. You were directed to submit proof of your income to confirm your eligibility by May 1, 2018 or you might lose your insurance or receive less help paying for your coverage.

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).

Also on February 1, 2018, NYSOH issued an enrollment notice confirming your enrolment in a qualified health plan with APTC, effective March 1, 2018. Additionally, on February 1, 2018, NYSOH issued a notice indicating the documentation received did not confirm the information in your application. You were directed to submit additional proof of your income by May 1, 2018.

On February 21, 2018, NYSOH issued an eligibility determination notice stating you were eligible for the Essential Plan with a \$20.00 monthly premium, for a limited time, effective February 1, 2018, because you had been granted Aid to Continue pending the decision in your appeal. You were reenrolled in an Essential Plan, effective February 1, 2018.

On March 19, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents. On April 3, 2018, the Appeals Unit received your documentation which was incorporated into the record as Appellant's Exhibit "1". The record closed thereafter.

## **Findings of Fact**

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

- 1) You testified that you are appealing your eligibility only, not your children's.
- 2) You were determined conditionally eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective November 1, 2017, with documentation of your income requested prior to January 1, 2018 to confirm your eligibility.
- 3) According to your account, no income documentation was received by the deadline.
- 4) On January 6, 2018, your eligibility was systematically redetermined and you were found ineligible for financial assistance, effective February 1, 2018 and disenrolled from your Essential Plan.
- 5) On January 31, 2018, NYSOH received two updated applications submitted on your behalf listing expected annual income for 2018 of \$15,000.00 and \$20,400.00, respectively.
- 6) Both applications indicated you would file your 2018 tax return with a tax filing status of single and you would claim no dependents. You testified that information was correct.

- 7) According to your account, NYSOH was unable to verify the income information in either of your applications.
- 8) The eligibility determination notice issued by NYSOH on February 1, 2018 was based on the final application submitted on January 31, 2018 which listed your annual income for 2018 as \$20,400.00. That notice indicated you were conditionally eligible for \$475.00 in APTC, effective March 1, 2018. You were directed to submit proof of your income by May 1, 2018 to confirm your eligibility.
- 9) Also on January 31, 2018, you submitted a copy of an unsigned and undated form 1040 purportedly from your 2016 tax return. According to your account, that documentation was invalidated by NYSOH the same day and you were directed to submit additional documentation of your income.
- 10) You appealed insofar as you were no longer eligible for the Essential Plan.
- 11) You were granted Aid to Continue in your Essential Plan, pending the decision in your appeal, and reenrolled effective February 1, 2018.
- 12) You testified that you are self-employed as a [REDACTED] [REDACTED] and [REDACTED]
- 13) You testified that you are not sure what your income will be for 2018 due to the variable nature of your work.
- 14) You testified that you project your income for 2018 will be less than your income for 2017 based on sales so far for the year.
- 15) You testified that you earn a portion of each trip transaction which is deposited into a [REDACTED] and that you have the ability to transfer those funds into your personal bank account, which you do daily.
- 16) You testified that, at the time of the hearing, you had not yet filed your tax return for 2017.
- 17) Your January 31, 2018 applications indicate that you will not take any deductions on your 2018 tax return. You testified that you will take a business expense deduction, but you are unsure of the amount of that deduction.
- 18) You were directed to submit proof of your income for 2018 in the form of three months of business income and expense reports. You were directed to submit a report for each month from December 2017 through February 2018, providing business income received in each of those months as well as business expenses incurred. You were directed to submit documentary

evidence supporting the information in the reports as well as net calculations for each month.

- 19) On April 3, 2018, the Appeals Unit received a single page document from you providing cumulative purported income and expenses for the period of January 1, 2018 through March 31, 2018. The expenses listed included "Car and truck," "Fees," "Loan principle," "Meals and entertainment," "Other business expenses," "Travel expenses," and "utilities." No additional documentation was submitted.
- 20) According to your applications, you reside in New York County.

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 funds 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.

### Verification Process

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 (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)).

## Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (see 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

The maximum amount of APTC that can be authorized equals:

- 1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

*minus*

- 2) the taxpayer's expected contribution amount

(see 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is \$12,060.00 for a one-person household (82 Federal Register 8831).

## Cost-Sharing Reductions

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level qualified health plan (45 CFR § 155.300(a), 45 CFR § 155.305(g)(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 2017 FPL, which is \$12,060.00 for a one-person household (82 Fed. Reg. 8831).

## **Legal Analysis**

The issue is whether NYSOH properly determined you were conditionally eligible to receive up to \$475.00 in APTC and ineligible for the Essential Plan, effective March 1, 2018.

Two updated applications were submitted on your behalf on January 31, 2018. The final application submitted that day, upon which the eligibility determination at issue was based, listed your annual expected income for 2018 as \$20,400.00 and indicated you were in one-person household, because you would file your 2018 tax return with a tax filing status of single and you would claim no dependents. According to your account, NYSOH was unable to verify the information in your applications.

Pursuant to the regulations, 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, NYSOH must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

On February 1, 2018, NYSOH issued an eligibility determination notice stating you were conditionally eligible to receive up to \$475.00 in APTC, effective March 1, 2018. Your eligibility was conditional upon you submitting sufficient evidence of your household income by May 1, 2018. You appealed that determination insofar as you were not eligible for the Essential Plan.

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).



Because the record established that NYSOH has been unable to verify the income information attested to in your January 31, 2018 applications, and because your testimony indicated that you were unsure of how much income you would earn in 2018, you were directed to submit proof of your income for 2018 in the form of three months of business income and expense reports. Specifically, you were directed to submit a report for each month from December 2017 through February 2018, providing business income received in each of those months as well as business expenses incurred with documentary evidence supporting the information in the reports and net calculations for each month.

Although you did submit documentation on April 3, 2018, that documentation did not conform to the documentation request. The documentation provided did not provide monthly income and expense information for three months, but rather provided information for a cumulative three-month period. Additionally, the expenses listed were not sufficiently specific enough to conclude that the full amounts listed were properly deductible nor was there any corroborating documentation submitted. Therefore, it is concluded that the income documentation provided was insufficient evidence of your income for 2018.

It is noted that you had previously submitted a copy of a form 1040 purportedly from your 2016 tax return which was invalidated by NYSOH. Aside from the unreliability of that documentation because it was neither signed nor dated, there is no evidence to suggest that the income information listed on the 2016 1040 was representative of your expected income for 2018. Additionally, the Appeals Unit has been unable to verify with state and federal data sources that your 2016 tax return was ever filed. Therefore, the 2016 form 1040 you previously submitted is not sufficient documentation of your income for 2018.

Since there is insufficient evidence in the record of your income for 2018, there is no factual basis upon which the Appeals Unit can overturn NYSOH's February 1, 2018 eligibility determination notice, stating you were eligible to receive up to \$475.00 in APTC, for a limited time, effective March 1, 2018. Accordingly, that determination must be AFFIRMED.

## **Decision**

The February 1, 2018 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** May 10, 2018

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

You remain conditionally eligible to \$475.00 in APTC.

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).

Your eligibility remains conditional upon you submitting sufficient proof of your income for 2018.

## **If You Disagree with this Decision (Appeal Rights)**

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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 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).

## **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  
PO Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

## **Summary**

The February 1, 2018 eligibility determination notice is AFFIRMED.

You remain conditionally eligible to \$475.00 in APTC.

Your eligibility remains conditional upon you submitting sufficient proof of your income for 2018.

## **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 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 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. yeb&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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