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

Notice of Decision

Decision Date: April 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028682

[redacted]

[redacted],

On April 18, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 29, 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: April 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028682

[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 January 1, 2018?

Procedural History

On December 28, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance. This application indicated that you had removed a dependent from your household, and included updated income information. That same day, a preliminary eligibility determination was issued stating that you were eligible to receive up to $376.00 per month in advanced payment of the premium tax credit (APTC) and eligible for cost-sharing reductions if you enrolled into a silver-level qualified health plan, for a limited time, and you were enrolled into a qualified health plan with the maximum amount of APTC applied to your monthly premium, effective January 1, 2018.

Also on December 28, 2017, a NYSOH representative validated the income documentation that was uploaded on your NYSOH account on December 20, 2018, updated your income information, and submitted an application on your behalf.

On December 29, 2017, NYSOH issued a plan enrollment notice, based on your plan selection on December 28, 2018, confirming your enrollment in a qualified

health plan with $376.00 in APTC applied to your monthly premium, both effective January 1, 2018.

On December 29, 2017, NYSOH also issued an eligibility determination notice, based on the second application that was submitted on December 28, 2017, stating that you were newly eligible to purchase a qualified health plan at full cost through NYSOH, effective February 1, 2018.

Also on December 29, 2017, NYSOH issued a plan enrollment notice stating that you were enrolled in a full pay qualified health plan through NYSOH, effective January 1, 2018.

On January 3, 2018, NYSOH received your updated application for financial assistance with health insurance.

On January 4, 2018, NYSOH issued an eligibility determination notice, based on your January 3, 2018 application, stating that you were eligible for up to $292.00 per month in APTC, effective February 1, 2018.

Also on January 4, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in a qualified health plan, effective January 1, 2018, and that $292.00 per month in APTC would be applied toward your premium as of February 1, 2018.

On February 8, 2018, you spoke to NYSOH's Account Review Unit and appealed the fact that you were found eligible for a full pay qualified health plan in the month of January 2018.

On April 18, 2018, 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 hearing.

Findings of Fact

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

1) According to your NYSOH account, both applications that were submitted on December 28, 2017, indicate that you expect to file your tax return for 2018 with a tax filing status of single and that you will claim no dependents on that tax return.

2) The first application that was submitted on December 28, 2017, listed an annual household income of $26,995.72, consisting of – (negative) $5,270.28 in income you earn from your corporation, $13,266.00 you earn from your employment, and $19,000.00 you earn in additional income.

3) You provided a copy of your 2016 amended federal tax return, on December 20, 2017, which indicates that in 2016 your adjusted gross income was $32,651.00.

4) On December 28, 2017, a NYSOH representative validated the income documentation that you uploaded to your NYSOH account on December 20, 2018 and changed your annual expected income from $29,995.72 to $64,917.00 and an updated application was submitted on your behalf.

5) The second application that was submitted on December 29, 2017 listed an annual expected income of $64,917.00, consisting of $32,651.00 you earn in income from your corporation, $13,266.00 you earned from your employment and $19,000.00 you earn in additional income.

6) You testified that you have no idea what your annual income for 2018 will be.

7) You testified that the closest estimate of your 2018 income, at the time of the hearing, would be about $33,236.00.

8) Your application states that you will not be taking any deductions on your 2018 tax return.

9) Your application states that you reside in Suffolk County, New York.

10) You testified that, due to NYSOH's incompetence, your annual expected income was changed without your consent which caused you to be found ineligible for APTC in the month of January 2018.

11) You testified that you filed the appeal because you should be entitled to APTC in the month of January 2018 and you would like your APTC to be applied to your January 2018 premium.

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 (*id*.).

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)).

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 January 1, 2018.

You are in a one-person household for purposes of this analysis. This is because both of the applications submitted on December 28, 2017, state that you expect to file your 2018 income taxes as single and will claim no dependents on that tax return.

On December 28, 2017, NYSOH validated your 2016 amended tax return that was submitted on December 20, 2017, as satisfactory documentation of your income and an application for financial assistance with health insurance was submitted on your behalf. The NYSOH representative changed your income that you receive from your corporation from – negative $5,270.28 to $32,651.00. This amount was added to the income you attested to earning from your employment in the amount of $10,266.00 and the $19,000.00 you earn in additional income, which resulted in an annual household income amount of $64,917.00.

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.

Your 2016 amended tax return, which the NYSOH representative allegedly relied upon when entering the income amounts into your December 28, 2017 application, shows that in 2016 you had an adjusted gross income of $32,651.00.

Therefore, the December 28, 2017 application was erroneously updated to include additional income that is not supported by the record. The application that was submitted should have only contained your adjusted gross income as listed on your tax return. At hearing, you testified that the closest estimate of your income for 2018 would be about $33,236.00, which is also the amount that was listed in your January 3, 2018 application.

Since the December 29, 2017 eligibility determination notice is not supported by the documentation you provided, as well as your testimony at the hearing, it is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of December 28, 2017, using a one-person household and an annual expected income of $33,236.00, for an individual residing in Suffolk County, New York, and to notify you accordingly regarding your eligibility for the month of January 2018.

This Decision has no effect on any subsequent notices issued by NYSOH regarding your eligibility and enrollment for the remainder of the 2018 coverage year.

Decision

The December 29, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of December 28, 2017, using a one-person household and an annual expected income of $33,236.00, for an individual residing in Suffolk County, New York, and to notify you accordingly regarding your eligibility for the month of January 2018.

This Decision has no effect on any subsequent notices issued by NYSOH regarding your eligibility and enrollment for the remainder of the 2018 coverage year.

Effective Date of this Decision: April 23, 2018

How this Decision Affects Your Eligibility

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).

This is not a final determination on your case.

Your case is being sent back to NYSOH to redetermine your eligibility, as of December 28, 2017, based on the factors noted above. NYSOH will notify you of its redetermination regarding your eligibility for the month of January 2018.

This Decision has no effect on your current eligibility, and will only affect your eligibility for the month of January 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 case 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.

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).

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 29, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of December 28, 2017, using a one-person household and an annual expected income of $33,236.00, for an individual residing in Suffolk County, New York, and to notify you accordingly regarding your eligibility for the month of January 2018.

This Decision has no effect on any subsequent notices issued by NYSOH regarding your eligibility and enrollment for the remainder of the 2018 coverage year.

This is not a final determination on your case.

Your case is being sent back to NYSOH to redetermine your eligibility, as of December 28, 2017, based on the factors noted above. NYSOH will notify you of its redetermination regarding your eligibility for the month of January 2018.

This Decision has no effect on your current eligibility, and will only affect your eligibility for the month of January 2018.

Legal Authority

We are sending you this notice in accordance with 45 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).

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 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.

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).