



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

Notice of Decision

Decision Date: May 8, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000030384



Dear [REDACTED],

On May 2, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 5, 2018 eligibility determination and enrollment notices.

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 8, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000030384



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 and your child were no longer eligible for financial assistance as of March 31, 2018?

Procedural History

On November 29, 2017, NYSOH issued an eligibility determination notice stating that you and your child were eligible to receive up to \$683.00 per month in advance payments of premium tax credit (APTC) and cost-sharing reductions (CSR) for a limited time, effective January 1, 2018. The notice directed you to provide proof of income by February 26, 2018, to confirm your household's eligibility.

On December 4, 2017, your NYSOH account was updated.

On December 5, 2017, NYSOH issued an eligibility determination notice stating that you and your child were eligible to receive up to \$551.00 per month in APTC for a limited time, effective January 1, 2018. The notice directed you to provide proof of income by February 26, 2018, to confirm your household's eligibility.

Also on December 5, 2017, NYSOH issued a plan enrollment notice confirming that as of December 4, 2017, you and your child were enrolled in a qualified health plan (QHP), with an enrollment start date of January 1, 2018. The notice directed you to provide proof of income by February 26, 2018, to confirm your household's eligibility.

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On February 20, 2018, your NYSOH account was updated.

On February 21, 2018, NYSOH issued an eligibility determination notice stating that you and your child were eligible to receive up to \$726.00 per month in APTC and CSR for a limited time, effective March 1, 2018. The notice directed you to provide proof of income by February 26, 2018, to confirm your household's eligibility.

Also on February 21, 2018, NYSOH issued a plan enrollment notice confirming that as of February 20, 2018, you and your child were enrolled in a QHP, with an enrollment start date of January 1, 2018. The notice directed you to provide proof of income by February 26, 2018, to confirm your household's eligibility.

On March 4, 2018, your NYSOH account was systemically updated.

On March 5, 2018, NYSOH issued an eligibility determination notice stating that you and your child were newly eligible to purchase a QHP at full cost, effective as of April 1, 2018. Further, both of you no longer qualified for financial assistance because you did not submit the documentation needed to verify the income listed in your application.

Also on March 5, 2018, NYSOH issued a plan enrollment notice confirming that you and your child were enrolled in a QHP, without financial assistance, with an enrollment start date of January 1, 2018.

On March 20, 2018, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your and your child's financial assistance through NYSOH was discontinued.

On April 24, 2018, you uploaded income documentation to your account (see Document [REDACTED]).

On May 2, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the hearing was closed at the end of the proceeding.

Findings of Fact

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

- 1) According to your NYSOH account, you are applying for health insurance for yourself and your [REDACTED] child.
- 2) You testified that you receive notices from NYSOH by the United States Postal Service.

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- 3) You testified that you did receive notices from NYSOH in December 2017 and February 2018.
- 4) You testified that you found out that you and your child were no longer eligible for financial assistance when you received the April 2018 premium statement from the health insurance company.
- 5) You testified that financial assistance was not applied to your April 2018 health insurance premium.
- 6) According to your NYSOH account, you expect to file a 2018 federal income tax return with the tax status of Head of Household (with qualifying individual), and expected to claim your child as a dependent on that tax return.
- 7) You testified 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.
- 8) On April 24, 2018, you submitted your 2017 Form 1040 U.S. Individual Income Tax Return to your account. Line 37 states that your adjusted gross income was \$36,939.00 (see Document [REDACTED]).
- 9) You testified that you expect your 2018 annual income to be similar to your 2017 annual income.
- 10) According to you NYSOH account, you and your child reside in [REDACTED].

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Verification of Eligibility for Advance Payments of the 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), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

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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)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective as of the first day of the month following the date of the notice (45 CFR § 155.310(f), 45 CFR § 155.330(e), (f)(1)(i)).

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

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).

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your child were no longer eligible for financial assistance as of March 31, 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. For individuals seeking APTC, 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 notices issued on November 29, 2017, and December 5, 2017, advised you that your and your child's eligibility for financial assistance was only conditional, and that you needed to submit documentation to confirm your household's income by February 26, 2018.

The record reflects that you receive notices from NYSOH by the United States Postal Service. Further, you testified that you did receive notices from NYSOH in December 2017 and February 2018. Therefore, it is concluded that NYSOH did provide you with proper notice that you needed to submit documentation of your income to confirm your and your child's eligibility for financial assistance.

If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine an individual's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation. Any changes in APTC are to be made effective the date following the eligibility redetermination notice. In your case, NYSOH did not receive any income documentation from you by the deadline to confirm your and your child's eligibility. Therefore, NYSOH properly ended your and your child's financial assistance as of March 31, 2018.

The March 5, 2018 eligibility determination and plan enrollment notices are **AFFIRMED**.

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.

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).

According to your NYSOH account, you attested that you expected to file a 2018 federal income tax return, with the tax status of Head of Household (with qualifying individual), and expected to claim your child as a dependent on that tax return.

However, you testified 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 are in a one-person household.

On April 24, 2018, you submitted your 2017 Form 1040 U.S. Individual Income Tax Return to your account. Line 37 states that your adjusted gross income was \$36,939.00 (Document [REDACTED]). Further, you testified that you expect your 2018 annual income to be similar to your 2017 annual income.

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], with a \$36,939.00 annual household income, and to notify you accordingly.

Decision

The March 5, 2018 eligibility determination and enrollment notices are 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], with a \$36,939.00 annual household income.

Effective Date of this Decision: May 8, 2018

How this Decision Affects Your Eligibility

You and your child were ineligible for financial assistance as of March 31, 2018, because NYSOH did not receive the income documentation within the time provided.

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 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

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- By fax: 1-855-900-5557

Summary

The March 5, 2018 eligibility determination and enrollment notices are 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], with a \$36,939.00 annual household income.

You and your child were ineligible for financial assistance as of March 31, 2018, because NYSOH did not receive the income documentation within the time provided.

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 issuing this determination 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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