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

Notice of Decision

Decision Date: June 17, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000005622

[redacted]

Dear [redacted],

On March 7, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's December 4, 2015 and December 20, 2015 eligibility determinations.

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 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: June 17, 2016

NY State of Health Account ID:
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Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you were eligible for $0.00 per month in advance payments of the premium tax credit, and that your son was eligible to enroll through Child Health Plus at $45.00 per month, effective January 1, 2016?

Procedural History

NYSOH received a revised application on December 3, 2015.

On December 4, 2015, NYSOH issued an eligibility determination notice based on the information contained in the December 3, 2015, stating that you were eligible to receive $0.00 per month in advance payments of the premium tax credit (APTC). The notice also stated that your son was eligible to enroll in Child Health Plus (CHP) for a cost of $45.00 per month. This eligibility determination was effective January 1, 2016.

Also on December 4, 2015, NYSOH issued an enrollment confirmation notice, stating that you had enrolled in a qualified health plan (QHP) with Empire BlueCross BlueShield (Empire BCBS) as of December 3, 2015. This notice also stated that your Empire BCBS plan coverage would begin on January 1, 2016 at a cost of $516.11 per month. Finally, the notice stated that your son enrolled in a CHP plan issued by UnitedHealthcare at a reduced premium rate of $45.00 per month, with such coverage beginning January 1, 2016.

On December 19, 2015, NYSOH received multiple revisions to your application. In response to the last application submitted on December 19, 2015, NYSOH prepared a preliminary eligibility determination stating that you were eligible for $0.00 per month in APTC, effective January 1, 2016. The preliminary eligibility determination also stated that your son was eligible for CHP at a cost of $45.00 per month.

Also on December 19, 2015, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were seeking a review of your eligibility for a greater amount of APTC and a review of your son's CHP coverage at $45.00 per month.

On January 12, 2016, NYSOH received two additional revisions to your application.

On January 13, 2016, NYSOH issued an eligibility determination notice based on your last application revision submitted on January 12, 2016, stating that you were eligible to enroll in the Essential Plan, effective February 1, 2016. The notice also stated that your son remained eligible for Medicaid, effective January 1, 2016. The notice also stated that your information would be sent to your local Department of Social Services, to see if you would qualify for Medicaid on a different basis.

Also on January 13, 2016, NYSOH issued a disenrollment notice, stating that your coverage under the Empire BCBS plan would end effective January 31, 2016. Similarly, the notice stated that your son's coverage under his CHP plan issued by UnitedHealthcare would end effective January 31, 2016. This notice was issued because neither you nor your son were eligible to remain enrolled in your current health insurance.

Also on January 13, 2016, NYSOH issued an enrollment notice, confirming that you had enrolled in an Essential Plan issued by Empire BCBS, with coverage beginning February 1, 2016 at a premium rate of $45.56 per month. The notice also confirmed that you son's Medicaid Managed Care (MMC) plan coverage with UnitedHealthcare would begin February 1, 2016.

Also on January 13, 2016, NYSOH issued a cancellation notice stating that your request to cancel your Essential Plan coverage had been received on January 12, 2016. The notice stated that your Essential Plan coverage would not take effect on February 1, 2016.

Finally, on January 26, 2016, NYSOH received an updated application.

On January 27, 2016, NYSOH issued an eligibility determination notice based on the information contained in that application. It stated that you were newly eligible to receive up to $184.00 per month in APTC and, if you selected a silver

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level plan, eligible for cost-sharing reductions (CSR), effective March 1, 2016. The notice also stated that your son was no longer eligible for Medicaid; however, his Medicaid coverage would continue until December 31, 2016.

On March 7, 2016, 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 support the following findings of fact:

1) You testified that you expect to file your 2016 taxes with a tax filing status of married filing jointly. You will claim your son as a dependent on that tax return.

2) You are seeking insurance for yourself and your son.

3) The application that was submitted on December 3, 2015 listed household income of $44,500.00 your spouse expected to earn from his employment with [redacted] $21,600.00 ($1,800.00 x 12 months) your spouse expected to receive from his Social Security benefits, $10,800.00 ($900.00 x 12 months) your son expected to receive from his Social Security benefits. This application also stated that you would be taking deductions totaling $47,388.00.

4) You live in New York County, New York.

5) The eligibility determination issued by NYSOH on December 4, 2015, which was based on the information contained in the December 3, 2015 application, was issued based on an annual household income of $59,100.00. You were found eligible for an APTC of $0.00 per month, and your son was found eligible for CHP at $45.00 per month, in each case beginning January 1, 2016.

6) Multiple revisions to your application were received on December 19, 2015. The last application that was submitted on that date reflected income your spouse would be receiving $7,416.00 between November 1, 2015 and December 1, 2015, would be receiving $44,500.00 as "additional income", $21,600.00 ($1,800.00 x 12 months) your spouse expected to receive from his Social Security benefits, $10,800.00 ($900.00 x 12 months) your son expected to receive from his Social Security benefits. This application also stated that you would be taking deductions in the amount of $63,278.00.

7) You testified that the December 19, 2015 application was erroneously submitted by a NYSOH representative since in included both duplications of both your spouse's income, but also duplicated certain deductions that your household would be taking on your 2016 tax return.

8) You were subsequently found eligible for the Essential Plan, effective February 1, 2016; and you were disenrolled from your health plan with Empire BCBS, effective January 31, 2016.

9) Prior to your enrollment in the Essential Plan, you submitted an additional application on January 26, 2016.

10) On January 27, 2016, you were found eligible for a tax credit of up to $184.00 per month; and your son was found eligible for Medicaid.

11) You testified that your January 13, 2016 application, which was submitted for eligibility processing on January 26, 2016, reflected your actual annual household income during 2016.

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)).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP 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 QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

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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).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible for an advance premium tax credit of $0.00 per month, and that your son was eligible to enroll through Child Health Plus at $45.00 per month, effective January 1, 2016.

You tested that with the assistance of a NYSOH representative, you submitted an application to NYSOH on December 3, 2015 with the intention of renewing your coverage for 2016.

The application that was submitted on December 3, 2015 listed an annual household income of $59,100.00 and the eligibility determination relied upon that information. However, the record reflects that you provided information to NYSOH indicating that you expected to receive: $44,500.00 your spouse expected to earn from his employment with [redacted] $21,600.00 ($1,800.00 x 12 months) your spouse expected to receive from his Social Security benefits, $10,800.00 ($900.00 x 12 months) your son expected to receive from his Social Security benefits. This application also stated that your household would be taking deductions totaling $47,388.00.

However, based solely upon a review of the income and deduction amounts provided, you expected to receive approximately $29,512.00 during 2016. Since the December 4, 2015 determination was based on an annual household income amount not reflective of the information contained in your application, it was issued in error and must be RESCINDED.

On December 19, 2015, NYSOH submitted several additional applications on your behalf. You testified that you contacted them over the phone to make certain adjustments to your application since you were unclear why you were not

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eligible for an APTC since your total income had remained unchanged from the previous year.

The last application that was submitted on that December 19, 2015 reflected income your spouse would be receiving $7,416.00 between November 1, 2015 and December 1, 2015, would be receiving $44,500.00 as "additional income", $21,600.00 ($1,800.00 x 12 months) your spouse expected to receive from his Social Security benefits, $10,800.00 ($900.00 x 12 months) your son expected to receive from his Social Security benefits. This application also stated that you would be taking deductions in the amount of $63,278.00.

NYSOH issued a determination on December 20, 2015 based on a total household income of $61,326.00, which was wholly inconsistent with income and deduction amounts that were provided in your application. Furthermore, you credibly testified that the determination appeared to be based on both duplicate and overlapping income and deduction amounts.

Since the December 20, 2015 determination was based on an annual household income amount not reflective of the information contained in your application, and contained erroneous income and deduction amounts, it was issued in error and must be RESCINDED.

The Marketplace received a further revised application on January 12, 2016, which while it apparently removed the duplicate income for your spouse, the duplicate deduction remained. As a result of this error, NYSOH issue an eligibility determination finding you were found eligible for Essential Plan coverage. Separately, your son was found eligible for Medicaid. Accordingly, the January 13, 2016 eligibility determination is also RESCINDED.

You testified that after further assistance from NYSOH on submitting applications, the only application that reflects your actual expected income during 2016 is the application submitted on January 13, 2016, which was later processed for your eligibility on January 26, 2016.

Therefore, your case is RETURNED to NYSOH to redetermine your household's eligibility as of January 1, 2016 using the information contained in the January 13, 2016 application.

Furthermore, NYSOH is directed to facilitate with plan management so that the appropriate deductible amounts, if any, can be credited to your account for coverage during 2016.

Decision

The December 4, 2015, December 20, 2015 and January 13, 2016 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household's eligibility as of January 1, 2016 using the information contained in the January 13, 2016 application.

Furthermore, NYSOH is directed to facilitate with plan management so that the appropriate deductible amounts, if any, can be credited to your account for coverage during 2016.

Effective Date of this Decision: June 17, 2016

How this Decision Affects Your Eligibility

You will receive a new determination from NYSOH reflecting your household's eligible for financial assistance as of January 1, 2016.

Your son is no longer eligible for Medicaid. His eligibility for financial assistance will be redetermined as of January 1, 2016, along with your own.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 4, 2015, December 20, 2015 and January 13, 2016 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household's eligibility as of January 1, 2016 using the information contained in the January 13, 2016 application.

NYSOH is directed to facilitate with plan management so that the appropriate deductible amounts, if any, can be credited to your account for the months of January and February of 2016.

You will receive a new determination from NYSOH reflecting your household's eligible for financial assistance as of January 1, 2016.

Your son is no longer eligible for Medicaid. His eligibility for financial assistance will be redetermined as of January 1, 2016, along with your own.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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A Copy of this Decision Has Been Provided To:

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