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

Notice of Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014005

[redacted]

Dear [redacted],

On March 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 13, 2016 eligibility determination.

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

Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014005

[redacted]

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 eligible to purchase a qualified health plan (QHP) at full cost, effective January 1, 2017, and not eligible to receive any financial assistance with the cost of your health insurance through NYSOH because your income is over the allowable income limit?

Procedural History

On November 3, 2016, you submitted an updated application for financial assistance and uploaded documentation to your NYSOH account.

On November 4, 2016, NYSOH issued a notice stating that your November 3, 2016 application had been reviewed, but that more information was needed to confirm the information in your application. The notice directed you to submit documentation of your income by November 18, 2016.

On November 18, 2016, NYSOH issued a notice stating that the documentation you had submitted did not confirm the information in your application, and that you needed to submit documentation of your income by December 3, 2016.

On November 25, 2016, you uploaded documentation to your NYSOH account.

On December 13, 2016, NYSOH issued notice of eligibility determination stating that you were eligible to purchase a QHP at full cost, effective January 1, 2017.

The notice also stated that you were not eligible for Medicaid, the Essential Plan, or to receive tax credits because the income in your application was over $47,520.00, which was above the allowable income limit for these programs.

On December 14, 2016, you spoke to NYSOH's Account Review Unit and appealed the December 13, 2016 eligibility determination, insofar as you were not found eligible for any financial assistance with the cost of health insurance through NYSOH.

On March 16, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open through April 7, 2017, to allow you to submit your 2016 form 1040 and proof of any income you received in the month of January 2017.

On March 22, 2017, you faxed documentation to the NYSOH Appeals Unit. No further documentation was received, and the record is now closed.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself only.

3) Your NYSOH account reflects that a NYSOH representative calculated your expected annual household income to be $128,615.00, and this amount was used to determine your eligibility for financial assistance on December 12, 2016.

4) You testified that this amount is not correct. You testified that you and a business partner have a small business. You testified that you and the business partner pay yourselves an income of $1,000.00 to $1,500.00 per month.

5) You testified that, if there are any net profits, they are divided by three, and that one third goes to you, one third goes to your partner, and one third goes back into the business.

6) You testified that you were not sure what your adjusted gross income for 2016 would be, as you were in the process of preparing your personal income tax return.

7) You testified that you submitted profit and loss statements in response to NYSOH's request for income documentation because you were not sure how to provide documentation of your income.

8) You submitted three profit and loss statements for the business in which you are a partner from the months of August, September, and October 2016. The statements showed net income as follows:

    a. August 2016: $25,835.59;
    b. September 2016: $6,318.16;
    c. October 2016: (-57,753.64)

    (Documents [redacted]).

9) You testified that the $57,753.64 loss shown in October 2016 is probably a result of the fact that the business is a [redacted] and [redacted] and that the money the business lays out for purchase and installation does not get recouped from the customer until 30 to 45 days later.

10) You testified that you hope your income will increase in 2017, but you do not know that this will occur.

11) After the hearing, you faxed a six-page document to NYSOH consisting of the following:

    a. A one-page cover sheet;
    b. The back of a check showing an endorsement and a January 23, 2017 date that appears to be the date that the check cleared;
    c. A two-page IRS Form 1040 for the year 2016 showing that your adjusted gross income for 2016 was $24,033.00;
    d. One page of an IRS Schedule E for 2016;
    e. A one-page document with the heading [redacted] stating that a check number [redacted] was paid to you in the amount of $1,000.00 on January 23, 2017

    Taken together, these documents are marked and entered into the record as "Appellant's Exhibit One."

12) Your 2016 1040 form shows a deduction for self-employment tax in the amount of $1,007.00 (Appellant's Exhibit One).

13) Your application states that you live in [redacted]

14) You testified that you are looking for any financial assistance that you may be eligible for to help you with enrolling in health insurance.

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)).

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 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

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 2016 FPL, which is $11,880.00 for a one-person household (81 Federal Register 4036.).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those

who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-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)).

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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036.).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for any financial assistance with the cost of health insurance through NYSOH as of January 1, 2017.

NYSOH updated your application on December 12, 2016 after you supplied profit and loss statements from the business in which you are a partner. It is not entirely clear what process NYSOH used to determine your expected annual gross income, but that income was listed as $128,615.00. This resulted in a determination that you were not eligible for any financial assistance from NYSOH, based on this income and your household size.

NYSOH bases its eligibility determinations on modified adjusted gross income, as defined in the federal tax code. During the hearing you testified that you were not sure what your gross income was for 2016, but that you were paid $1,000.00 to $1,500.00 per month from the business, and that you received a share of net profits as well.

After the hearing, you uploaded documents that show that your adjusted gross income for 2016 was $24,033.00. You also uploaded documentation showing that you received income of $1,000.00 in the month of January 2017. You testified that you expected your 2017 income to be the same or more. You also testified that you expect to file your 2017 tax return with a tax filing status of single, and to claim no dependents.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable

family size. However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted documentation that shows that your monthly income for January 2017 was $1,000.00.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,366.20 per month. Since the documentation you provided shows that you earned $1,000.00 in January 2017, you might qualify for Medicaid based on monthly income as of the January 1, 2017.

Since the December 13, 2016 eligibility determination improperly stated that, based on the information you provided, you were not eligible to receive financial assistance through NYSOH, it was not correct and is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid, based on a monthly income of $1,000.00 for a one-person household, effective January 1, 2017.

NYSOH is directed to promptly issue an eligibility determination in writing notifying you of your eligibility.

Decision

The December 13, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid, based on monthly income of $1,000.00 for a one-person household in [redacted], effective January 1, 2017.

Effective Date of this Decision: April 21, 2017

How this Decision Affects Your Eligibility

NYSOH's determination that you were not eligible for financial assistance beginning January 1, 2017 was not correct.

Your case is being sent back to NYSOH to determine your eligibility for Medicaid, based on monthly income of $1,000.00 for the month of January 2017, effective January 1, 2017.

NYSOH will promptly notify you of its decision in writing.

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
- By fax: 1-855-900-5557

Summary

The December 13, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid, based on monthly income of $1,000.00 for a one-person household in [redacted], effective January 1, 2017.

NYSOH's determination that you were not eligible for financial assistance beginning January 1, 2017 was not correct.

Your case is being sent back to NYSOH to determine your eligibility for Medicaid, based on monthly income of $1,000.00 for the month of January 2017, effective January 1, 2017.

NYSOH will promptly notify you of its decision in writing.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

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 नि:शुल्क 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).