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

Notice of Decision

Decision Date: May 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015033

[redacted]

Dear [redacted],

On April 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 22, 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).

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

Decision

Decision Date: May 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015033

[redacted]

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 to receive up to $327.00 per month in advance payments of the premium tax credit, effective March 1, 2017?
>
> Did NYSOH properly determine that you were eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan.
>
> Did NYSOH properly determine that you were eligible for Medicaid?

Procedural History

On June 27, 2016, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid, effective June 1, 2016.

Also on June 27, 2016, NYSOH issued an enrollment notice confirming your selection of a Medicaid Managed Care (MMC) plan as of June 27, 2016. The notice confirmed your coverage under this MMC had begun as of April 1, 2016.

On December 3, 2016, NYSOH issued a renewal and eligibility determination notice stating that you now qualified for health care coverage under the Essential

plan, effective February 1, 2017. This was because federal and state data sources show that your income is between $17,820.00 and $23,760.00.

On December 17, 2016, NYSOH issued a disenrollment notice confirming that your MMC plan coverage would end effective January 31, 2017.

Also on December 17, 2016, NYSOH issued an enrollment notice confirming your enrollment in an Essential Plan as of December 16, 2016. The notice stated that your Essential Plan coverage would begin effective February 1, 2017.

On December 30, 2016, NYSOH received an update to your application for health insurance, in which you reflected an annual household income of $6,279.72. In response to this update to your application, NYSOH prepared a preliminary eligibility determination stating that your eligibility could not be determined without additional information. No written notice reflecting this finding was issued to you.

Also on December 30, 2016, NYSOH received earnings statements issued to you by your employer, [redacted]., on October 14, 2016 and December 15, 2016.

On December 31, 2016, NYSOH issued a disenrollment notice confirming that your Essential Plan coverage had been cancelled as of February 1, 2017.

On January 11, 2017, NYSOH issued a notice stating that the documents you provided was not sufficient to resolve the inconsistency in your account. You were requested to provide income documentation by January 14, 2017 to confirm the information contained in your account so that an appropriate determination could be issued.

On January 12, 2017, NYSOH received earnings statements issued to you by [redacted] on December 29, 2016.

On January 21, 2017, NYSOH redetermined your eligibility based on the information contained in your account as of that date.

On January 22, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for an advance premium tax credit (APTC) of up to $327.00 per month; eligible for cost-sharing reductions (CSR), provided you selected a silver level plan; ineligible for the Essential Plan and ineligible for Medicaid. This eligibility determination was effective March 1, 2017.

On January 23, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that determination insofar as you were not found eligible for either the Essential Plan or Medicaid.

Prior to the scheduled hearing, on April 12, 2017, NYSOH received a letter from your employer, dated March 30, 2017, stated that your annual salary had been increased from $8,587.44 to $8,736.00, which was the result of a retroactive increase. It further stated that your hourly rate is equivalent to $12.00.

On April 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: all earnings statements issued to you by your employer during the months of February and March 2017. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier.

That same day, you provided the above referenced documents to the Appeals Unit through your NYSOH online account.

Accordingly, the record was closed on April 12, 2017.

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) The application that was submitted on December 30, 2016 listed annual household income of $6,279.00, consisting of solely of income you received from your employer, [redacted]. You testified that this amount was correct.

4) In response to your December 30, 2016 application, NYSOH requested that you provide additional income documentation by January 14, 2017 to confirm your eligibility.

5) On December 30, 2016, you provided to NYSOH two earnings statements reflecting that you received from your employer (1) $473.52 on October 14, 2016 and (2) $872.28 on December 15, 2016. These documents were deemed by NYSOH to be insufficient to resolve the discrepancy in your application since they were not consecutive earnings statements. You were requested to provide additional income documentation by January 14, 2017.

6) On January 12, 2017, you provided to NYSOH an additional earnings statement issued to you, which reflected that you received $968.88 on December 29, 2016.

7) On January 21, 2017, NYSOH redetermined your eligibility based on an annual household income of $23,935.08.

8) You testified that your anticipated earnings will be much less than $23,935.08 during 2017. You provided a letter from your employer, dated March 30, 2017, stating that your annual salary for 2017 had been increased from $8,587.44 to $8,736.00.

9) Your application states that you will not be taking any deductions on your 2017 tax return.

10) You live in Kings County, New York.

11) You testified that you were seeking to be found eligible for the Essential Plan or Medicaid, rather than tax credits, because the plans available through NYSOH are unaffordable without greater assistance.

12) On April 12, 2017, at the direction of the Hearing Officer, you provided several earnings statements reflecting that you received from your employer (1) $753.28 on February 15, 2017, (2) $934.79 on February 28, 2017, (3) $472.34 on March 15, 2017 and (4) $785.68 on March 31, 2017.

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 2016 is set by federal law at 2.03% to 9.66% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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 (80 Federal Register 3236, 3237).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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.).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

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 (80 Federal Register 3236, 3237).

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).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to $327.00 per month.

The application that was submitted on December 30, 2016 contained an attestation by you that your annual household income was $6,279.72. However, since state and federal records did not coincide with that income figure, you were requested to provide additional income documents, ultimately, by January 14, 2017.

The record reflects that on December 30, 2016, you provided to NYSOH two earnings statements reflecting that you received from your employer (1) $473.52 on October 14, 2016 and (2) $872.28 on December 15, 2016.

The record further reflects that on January 12, 2017, you provided to NYSOH an earning statement issued to you on December 29, 2016 which reflected that you received $968.88.

Based on these income documents, NYSOH redetermined your eligibility based on an annual household income of $23,935.08, which computed based on average income received by you during December 2016 ($1,841.16 / 4 weeks = $460.29 per week). Therefore, based on your anticipated weekly earnings of $460.29, you were found to have an annual household income of $23,935.08 ($460.29 x 52 weeks). The eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

You reside in Kings County, where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $23,935.08 is 201.43% of the 2016 FPL for a one-person household. At 201.43% of the FPL, the expected contribution to the cost of the health insurance premium is 6.48% of income, or $129.30 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county ($456.46 per month) minus your expected contribution ($129.30 per month), which equals $327.16 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $327.00 per month in APTC.

The second issue is whether you were properly found eligible for CSR.

CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of $23,935.08 is 201.43% of the applicable FPL, NYSOH correctly found you to be eligible for CSR.

The third issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $23,935.08 is 201.43% of the 2016 FPL, NYSOH properly found you to be not eligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that you were ineligible for Medicaid.

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 (MAGI) that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since $23,935.08 is 201.43% of the 2016 FPL, NYSOH properly found you to be not eligible for Medicaid on an expected annual income basis, using the information provided in your application.

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 earnings statements that shows in December 2016 you received $1,841.16, and you later submitted additional earnings statements reflecting that your received $1,688.07 during February 2017, and $1,258.02 during March 2017.

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 $1,367.00 per month. Since the documentation you provided shows that you earned $1,841.16 in December 2016 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the January 22, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $327.00 per month in APTC, eligible for CSR, and not eligible for the Essential Plan and Medicaid, it is correct and is AFFIRMED.

However, the record reflects that you provided documentation reflecting that you received $1,258.02 during March 2017, which is less than the $1,367.00 monthly limit for Medicaid eligibility for a one-person household.

Accordingly, your case is RETURNED to NYSOH to redetermine your eligibility based on a monthly household income of $1,258.02 in a one-person household in Kings County.

Decision

The January 22, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a monthly household income of $1,258.02 in a one-person household in Kings County.

Effective Date of this Decision: May 19, 2017

How this Decision Affects Your Eligibility

Your eligibility has not changed, as you were properly found eligible for an APTC of up to $327.00 per month, eligible for CSR, and not eligibility for Essential Plan and Medicaid as a result of the January 22, 2017 eligibility determination.

You will, however, receive a new eligibility determination based on a monthly household income of $1,258.02 in a one-person household in Kings County.

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 January 22, 2017 eligibility determination notice is AFFIRMED.

Your eligibility has not changed, as you were properly found eligible for an APTC of up to $327.00 per month, eligible for CSR, and not eligibility for Essential Plan and Medicaid as a result of the January 22, 2017 eligibility determination.

You will, however, receive a new eligibility determination based on a monthly household income of $1,258.02 in a one-person household in Kings County.

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)

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).

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।

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)

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).

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).