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

Notice of Decision

Decision Date: July 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016685

[redacted]

Dear [redacted],

On June 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 8, 2017 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
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Decision

Decision Date: July 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016685

[redacted]

Issues

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

> Did NY State of Health properly determine that your family was eligible to receive up to $166.00 per month in advance payments of the premium tax credit, effective February 1, 2017?
>
> Did NY State of Health properly determine that your family was not eligible for Medicaid?

Procedural History

On March 8, 2017, NY State of Health (NYSOH) prepared a preliminary eligibility determination finding your family eligible to share in up to $166.00 per month in advance payments of the premium tax credit (APTC), effective February 1, 2017.

On March 8, 2017, you spoke to NYSOH's Account Review Unit and appealed your family's financial assistance and the denial of a special enrollment period.

On March 9, 2017, NYSOH issued an eligibility determination notice, based on your March 8, 2017 updated application, stating that your family was eligible to share in up to $166.00 per month in APTC, effective February 1, 2017. That notice also stated that your family does not meet the eligibility requirements for Medicaid nor does it qualify for a special enrollment period.

On June 30, 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 to July 14, 2017, to allow you to submit supporting documents.

On July 14, 2017, you submitted your profit and loss statement for the months of January 2017 through April 2017. These documents were made part of the record as "Appellant's [redacted]." No further documentation was received as of that date 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 married filing jointly. You will claim one dependent on that tax return.

2) You are seeking insurance for your family.

3) According to your NYSOH account, your family was to be enrolled in a silver-level qualified health plan (QHP) as of February 1, 2017, with a monthly premium responsibility of $1, 222.00 ([redacted]

4) Also, according to your NYSOH account, your family was disenrolled from that same silver-level QHP, effective February 1, 2017, because you did not pay your insurance bill by the payment deadline [redacted].

1) The application that was submitted on March 3, 2017 listed annual household income of $20,905.04, consisting of $1,386.00 you earn from your self-employment and $19,519.04 your spouse receives in self-employment income. You testified, and submitted documentation to show, that this amount was correct.

2) Your application states that you will be taking deductions on your 2017 tax return, including the deductible portion of your self-employment tax and additional adjustments.

3) According to Appellant's Exhibit A, in March 2017, your earnings were -$232.15 and your spouse's earnings were $2,394.00, which equals a monthly income of $2,161.85.

4) Your application states that your family lives in [redacted], New York.

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)).

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 $ 20,160.00 for a three-person household (81 Federal Register 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 2017 FPL, which is $20,420.00 for a three-person household (82 Fed. Reg. 8831).

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 under review is whether NYSOH properly determined that your family was eligible for an APTC of up to $166.00 per month.

The application that was submitted on March 8, 2017 listed an annual household income of $20,905.04. You testified, and submitted documentation, that this amount was correct.

However, your application states that you will be taking deductions on your 2017 tax return, including the deductible portion of your self-employment tax and additional adjustments. Since you did not supply proof of these deductions, they are not considered in this Decision. Therefore, NYSOH properly determined that your annual gross household income was $20,905.04, based on the information you provided.

Your family is in a three-person household. You expect to file your 2017 income taxes as married filing jointly and will claim one dependent on that tax return.

APTC 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 between 138% and 400% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $20,160.00 for a three-person household. Since, an annual income of $20,905.04 is 103.7% of the 2016 FPL for a three-person household, NYSOH improperly found your family to be eligible for APTC on an expected annual income basis, using the information provided in your application.

The second issue under review is whether NYSOH properly determined that your family was 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 that is at or below 138% of the FPL for the applicable family size. Since there is no indication that your family does not meet the non-financial criteria for Medicaid eligibility, this decision turns to whether your family meets the financial criteria for Medicaid eligibility.

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine a family’s eligibility. Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

On the date of your application, 100% of the 2017 FPL was $20,420.00 for a three-person household, which is $1,702.00 per month or $2,349.00 at 138% of the applicable FPL. Since annual income of $20,905.04 is 102.34% of the 2017

FPL and your household's Marcy 2017 income of $2,161.85 was below the allowable maximum monthly income limit of $2,349.00, NYSOH improperly found your family to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application. The same applies for a monthly income analysis as deduced during the appeals process.

Since the March 9, 2017 eligibility determination improperly stated that your family was eligible to share in up to $166.00 per month in APTC and ineligible for Medicaid, it is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance in 2017, as of March 8, 2017, based on an annual household income of $20,905.04 or a monthly income of $2,161.85. as the case may be, and a three-person household, for a couple with one dependent residing in [redacted]

Decision

The March 9, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance in 2017, as of March 8, 2017, based on an annual household income of $20,905.04 or a monthly income of $2,161.85. as the case may be, and a three-person household, for a couple with one dependent residing in [redacted].

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

Effective Date of this Decision: July 26, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your family's eligibility. Your case is being sent back to NYSOH to re-determine your family's eligibility for financial assistance in 2017, as of March 8, 2017, based on the above-noted criteria.

Your family's eligibility to enroll in an insurance affordability program through NYSOH will depend on NYSOH's redetermination.

NYSOH will notify you to inform you of what further action may be required on your part, if applicable.

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 March 9, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance in 2017, as of March 8, 2017, based on an annual household income of $20,905.04 or a monthly income of $2,161.85. as the case may be, and a three-person household, for a couple with one dependent residing in [redacted].

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

This is not a final determination of your family's eligibility. Your case is being sent back to NYSOH to re-determine your family's eligibility for financial assistance in 2017, as of March 8, 2017, based on the above-noted criteria.

Your family's eligibility to enroll in an insurance affordability program through NYSOH will depend on NYSOH's redetermination.

NYSOH will notify you to inform you of what further action may be required on your part, if applicable.

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 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.

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