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

Notice of Decision

Decision Date: November 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019724

[redacted]

Dear [redacted],

On September 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 31, 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: November 3, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000019724

[redacted]

Issues

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

> Did NY State of Health properly determine you were not eligible for the Essential Plan?
>
> Did NY State of Health properly determine you were not eligible for Medicaid?
>
> Did NY State of Health properly determine you were not eligible to receive advance payments of the premium tax credit?

Procedural History

On July 16, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective July 1, 2016. You were subsequently enrolled in a Medicaid Managed Care (MMC) plan with a plan start date of August 1, 2016.

On May 4, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming annual period. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by June 15, 2017 or you might lose the financial assistance you were currently receiving.

On May 30, 2017, you submitted an updated application for financial assistance.

On May 31, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost, effective July 1, 2017. That notice also stated that you were not eligible for Medicaid, Child Health Plus, or the Essential Plan because you did not meet the income limits or other eligibility standards for those programs. You were not eligible to received advance payments of the premium tax credit (APTC), because your application stated you did not plan to file a federal income tax return.

Also on May 31, 2017, NYSOH issued a disenrollment notice stating that your coverage with your MMC plan would end on June 30, 2017 because you were no longer eligible to enroll in the plan.

On June 12, 2017, NYSOH received your letter requesting an appeal of NYSOH May 31, 2017 eligibility determination and disenrollment notices.

On June 14, 2017, NYSOH issued a confirmation notice that you requested an appeal of the May 31, 2017 eligibility determination notice.

On September 15, 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 up to October 2, 2017, to allow you to submit supporting documents.

On September 18, 2017, the NYSOH Appeals Unit received via secure facsimile your three-page submission, which included a cover page, an earnings statement from [redacted], dated 8/31/2017, and a one page document titled "Payment Details" that indicates a manual check was issued to you on 8/18/2017. Collectively these documents were made part of the record as Appellant's Exhibit # 1. The record was closed at that time.

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.

3) The updated application that was submitted on May 30, 2017 listed annual household income of $31,200.00, based on your earning $15.00 an hour and working a regular 40-hour week. You testified that this information is not accurate.

4) You testified that your rate of pay is $10.00/hour and $15.00/hour for overtime. You testified that you work in [redacted] for [redacted] and your weekly hours vary.

5) The May 30, 2017 application indicates that you will not be filing taxes in 2017.

6) You testified that you have no idea why the May 30, 2017 application states you will not be filing taxes in 2017, as you always file a tax return and intend to do so this year.

7) You submitted to NYSOH on June 12, 2017, a copy of your 2016 income tax return showing you earned $11,233.00 in wages in 2016.

8) On September 18, 2017, you submitted a pay stub purporting to be for a manual check, dated 8/18/2017, for 68 regular hours with gross pay of $1,020.00 and an earnings statement from [redacted], dated 8/31/2017, for pay period 8/14/2017 thru 8/27/2017 with gross pay of $897.50 (80 hours at $10.00/hr and 6.50 hours at $15.00/hr). The year to date total gross wages was $12,255.00.

9) You testified that you will not be taking any deductions on your 2017 tax return.

10) There is no evidence in your NYSOH account that you have ever received APTC.

11) According to your NYSOH account and your testimony you are single.

12) Your application states that you live in [redacted], New York.

13) You testified that you need insurance because you have ongoing medical issues.

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

Applicable Law and Regulations

Attestation to File Tax Return

The advance premium tax credit (APTC) is 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 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)).

NY State of Health may authorize APTC only when it obtains certain necessary attestations from the tax filer, including an attestation that he will file an income tax return for the benefit year (45 CFR § 155.310(d)(2)(ii)(A)).

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 Federal Register 4036).

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 2017 FPL, which is $12,060.00 for a one-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).

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).

Legal Analysis

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

You submitted an updated application on May 30, 2017. According to your account, NYSOH used $15.00/hour as your wage rate in calculating your estimated annual income of $31,200.00 ($15.00/hour x 40 hours x 52 weeks). You testified that the estimated income calculated by NYSOH was inaccurate. You further testified that you work in [redacted] for [redacted]., your rate of pay is $10.00/hour and $15.00/hour for overtime, and your weekly work hours vary.

You testified that you intend to submit a 2017 income tax return and are not sure why your May 30, 2017 application states that you will not be filing a tax return. You submitted a copy of your 2016 income tax return. While the income on this 2016 return is not indicative of your estimated 2017 income, it is credible evidence of your testimony that you do file tax returns on a yearly basis.

You submitted after the hearing, two documents purporting to be pay advices you received in the month of August 2017. The first document is marked “Payment Details” that indicates a manual check was issued to you on 8/18/2017 for 68 regular hours with gross pay of $1,020.00. The second document is an earnings statement from [redacted] dated 8/31/2017, for pay period of 8/14/2017 through 8/27/2017 with gross pay of $897.50 (80 hours at $10.00/hour and 6.50 hours at $15.00/hour). The year to date total gross wages was $12,157.50.

Based on the credible evidence of record, it is concluded that NYSOH incorrectly determined your household income to be $31,200.00 based on $15.00/hour. It should have calculated your expected earnings for 2017 as $20,800.00 ($10.00/hour x 40 hours x 52 weeks.)

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. You testified that you will file a 2017 income tax return with a tax filing status of single.

Because NYSOH used the incorrect amount as your annual expected earnings for 2017 and because you testified you do intend to file a 2017 tax return, the

May 31, 2017 eligibility determination notice was incorrect and must be RESCINDED in relevant part.

The second issue under review is whether NYSOH properly determined 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 that is at or below 138% of the FPL for the applicable family size. On the date of your May 30, 2017 application, the relevant FPL was $12,060.00 for a one-person household.

As stated above, NYSOH used the incorrect income amount of $31,200.00 as your expected 2017 income in determining your eligibility for Medicaid, in the May 31, 2017 eligibility determination notice. As NYSOH improperly found you ineligible for Medicaid on an expected annual basis for 2017, the May 31, 2017 eligibility determination is RESCINDED in relevant part.

The third issue under review is whether NYSOH properly determined you were not eligible to receive APTC.

The eligibility determination notice issued by NYSOH on May 31, 2017, indicated you were not eligible to receive APTC, because you indicated you would not file a federal tax return, or you were married and filing your taxes separately from your spouse, or you received APTC in a prior year in which you did not file a federal tax return.

There is no evidence in the record that you have ever received APTC. According to the record, you are single and have no dependents. While your May 30, 2017 application indicates you do not intend to file a 2017 income tax return, you testified that you will file a 2017 income tax return. You submitted a copy of your 2016 income tax return, which is credible evidence of your testimony that you file a tax return every year and intend to file in 2017.

Therefore, the May 31, 2017 eligibility determination notice stating you are not eligible to receive APTC, because you did not intend to submit a 2017 income tax return or were married and filing your taxes separately from your spouse, or that APTC were made in a prior year and not reported on your federal tax return is not supported by the record and must be RESCINDED in relevant part.

Your case is RETURNED to NYSOH to redetermine your eligibility to receive financial assistance using an annual income of $20,800.00, a household size of one, and a marital and tax filing status of single for an individual residing in New York County.

Decision

The May 31, 2017 eligibility determination notice is RESCINDED in its entirety.

Your case is RETURNED to NYSOH to redetermine your eligibility to receive financial assistance using an annual income of $20,800.00, a household size of one, and a marital and tax filing status of single for an individual residing in New York County.

Effective Date of this Decision: November 3, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility, as of May 30, 2017, based on an annual income of $20,800.00, a household size of one, and a marital and tax filing status of single for an individual residing in New York County.

You will receive a notice from NYSOH with an updated eligibility determination.

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 May 31, 2017 eligibility determination notice is RESCINDED in its entirety.

Your case is RETURNED to NYSOH to redetermine your eligibility to receive financial assistance using an annual income of $20,800.00, a household size of one, and a marital and tax filing status of single for an individual residing in New York County.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility, as of May 30, 2017, based on an annual income of $20,800.00, a household size of one, and a marital and tax filing status of single for an individual residing in New York County.

You will receive a notice from NYSOH with an updated eligibility determination.

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).

Legal Authority

We are sending you this notice in accordance with 45 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).

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 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.

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).

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).