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

Notice of Decision

Decision Date: November 08, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020370

[redacted]

On September 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 25, 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 08, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000020370

[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 you were eligible to receive up to $220.00 per month in advance payments of the premium tax credit, effective August 1, 2017?
>
> Did NY State of Health properly determine that you were ineligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were ineligible for the Essential Plan?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On June 25, 2017, NY State of Health (NYSOH) issued an eligibility determination notice, based on your June 24, 2017 updated application, stating that you were eligible to receive up to $220.00 per month advance premium tax credits (APTC) to use towards the purchase of health insurance and ineligible for cost-sharing reductions, effective August 1, 2017.

On July 11, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination notice as it related to the level of your financial assistance.

On July 13, 2017, based on your request for Aid to Continue being granted, NYSOH issued an eligibility determination notice stating you were Medicaid eligible for a limited time until a decision is made on your appeal, effective August 1, 2017. NYSOH also issued a plan enrollment notice stating that you had coverage through your Medicaid Managed Care plan, effective August 1, 2017.

On September 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open to October 11, 2017 for you to submit supporting documentation.

On September 28, 2017, you submitted a letter from your employer indicating that your last assignment ended July 2, 2017. This document was made part of the record as "Appellant's Exhibit A." On September 28, 2017, you submitted a copy of your profit and loss statements for July 2017 through September 2017; three paystubs dated June 16, 2017 through June 30, 2017; and a letter requesting that rent and other living expenses be considered. These documents were made part of the record as "Appellant's Exhibit B."

As of October 11, 2017, the Appeals Unit did not receive any further documentation from you nor were there any additional documents visible in your NYSOH account. Therefore, the record was closed on October 11, 2017.

Findings of Fact

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

1) According to your NYSOH account and your testimony, 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 application that was submitted on June 24, 2017, listed annual household income of $32,175.00 in earnings from your employment. You testified that these were the earnings from January 1, 2017 through June 30, 2017, but that you no longer work for that employer. You believe your last pay date was the first Friday in July 2017.

4) According to your submitted documentation, as of June 25, 2017 you earned $34,893.81 in earned income and received at least $4,228.13 in earned income in the month of June 2017 based on adding the three weekly paystubs you submitted dated June 16, 2017 through June 30, 2017 in the amount of $1,425.00, $1,378.13, and $1,425.00, respectively. These documents further show that you received your pay on Fridays and

that you did not include the first two paystubs for June 2017 (*see* Appellant's Exhibit B, p.1).

5) According to your NYSOH account, you will not be taking any deductions on your 2017 tax return. You testified this is incorrect because you are now self-employed and hope to take business expense deductions off your tax return.
6) Your letter from your employer shows that you worked for your employer until July 2, 2017. You did not submit your last paycheck that you received in July 2017. As such, your income from July 2017 is unknown (*see* Appellant's Exhibit A, p. 2).

7) You testified, and submitted documentation to show, that you are currently self-employed and that after business expense deductions are excluded from income, you will show a loss for the remainder of 2017. Your documents specifically show that in July 2017, you had a business loss of $1,882.02, in August 2017, you had a business loss of $839.11 and, in September 2017, you had a business loss of $1,608.11. You testified that you had no other income in each of these three months, except in July 2017 you received one paystub that you did not submit. As such, your expected 2017 modified adjusted gross annual income is $0.00 as of August 2017 (*see* Appellant's Exhibit B, pp. 2-4).

8) According to your NYSOH account and your testimony, you live in [redacted]

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 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).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between *8.21*% and 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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).

<u>Cost-Sharing Reductions</u>

Cost-sharing reductions 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.).

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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to receive an APTC of up to $220.00 per month.

In the application that was submitted on June 24, 2017, you attested to an expected yearly income of $32,175.00, and the eligibility determination relied upon that information. During the hearing, you testified that these were the earnings from January 1, 2017 through June 30, 2017, but that you no longer work for that employer. You believe your last pay date was the first Friday in July 2017. Since you failed to supply your last paystub from your employer, which you received in July 2017, your income for July 2017 is not ascertainable. However, you credibly testified and submitted documentation that shows you are self-employed and that as of August 2017 your expected annual modified gross annual household income is $0.00.

Regardless, according to your testimony, and your submitted documentation, when you applied for financial assistance on June 24, 2017, you were still employed and receiving income from your employer. In fact, your testimony and submitted documentation reflects that you should have received another paystub on the first Friday in July 2017. As such, NYSOH properly determined that your income, at the time of your application, was $32,175.00 for 2017.

You are in a one-person household. This is because 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 $32,175.00 is 212.20% of the 2016 FPL for a one-person household. At 270.83% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 8.83% of income, or $236.75 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 ($236.75 per month), which equals $219.71 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible to receive up to $220.00 per month in APTC, as of the date of your application.

The second issue under review is whether you were properly found ineligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of $32,175.00 is 270.83% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions, as of the date of your application.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan, effective August 1, 2017.

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 $32,175.00 is 270.83% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan, as of the date of your application.

The fourth issue under review 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 that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since $32,175.00 is 266.79% of the 2017 FPL, NYSOH properly found you to be ineligible 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.

Your submitted documentation, which includes three out of five paystubs you received in June 2017, shows that in the month of June 2017 you received at least $4,228.13 in employment income.

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 $1,387.00 per month. Since your submitted documentation shows that you earned at least $4,228.13 in June 2017, which exceeds the monthly allowable income threshold, you did not qualify for Medicaid based on monthly income as of the date of your application.

Since the June 25, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to $220.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

However, since the record now contains a more accurate representation of your 2017 expected modified adjusted gross annual household income of $0.00 as of August 1, 2017, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a modified adjusted gross annual household income of $0.00 per year, and a one-person household, for an

individual residing in Kings County, New York. NYSOH might require additional documentation from you to redetermine your eligibility for financial assistance.

Decision

The June 25, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a modified adjusted gross annual household income of $0.00 per year, and a one-person household, for an individual residing in Kings County, New York, and to notify you accordingly. NYSOH might require additional documentation from you to redetermine your eligibility for financial assistance.

Effective Date of this Decision: November 08, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

While your eligibility for financial assistance was based on your attestation of income and, therefore was correct as of your June 24, 2017 application, your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2017 based on the information noted above. NYSOH will notify you of its redetermination and/or 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 June 25, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a modified adjusted gross annual household income of $0.00 per year, and a one-person household, for an individual residing in Kings County, New York, and to notify you accordingly. NYSOH might require additional documentation from you to redetermine your eligibility for financial assistance.

This is not a final determination of your eligibility.

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).

While your eligibility for financial assistance was based on your attestation of income and, therefore was correct as of your June 24, 2017 application, your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2017 based on the information noted above. NYSOH will notify you of its redetermination and/or what further action may be required on your part, if applicable.

Legal Authority

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A Copy of this Decision Has Been Provided To:

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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.

한 국 어 (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.

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).

(Bengali)

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1-855-355-5777

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.

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(Yiddish) אידיש

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).