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

Notice of Decision

Decision Date: October 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020520

[redacted]

Dear [redacted],

On October 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 13, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: October 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000020520

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly end your Medicaid eligibility and coverage in your Medicaid Managed Care plan, effective July 31, 2017?
>
> Did NYSOH properly determine that you were eligible to receive up to $189.00 per month in advance payments of the premium tax credit (APTC), ineligible for cost-sharing reductions, and ineligible for the Essential Plan?

Procedural History

On November 9, 2016, NYSOH systematically redetermined your eligibility.

On November 10, 2016, NYSOH issued an eligibility redetermination notice stating that you were eligible for Medicaid, effective November 1, 2016.

Also, on November 10, 2016, NYSOH issued a notice of enrollment confirmation stating that you remained enrolled in your Medicaid Managed Care plan effective August 1, 2015.

On June 18, 2017, NYSOH issued a renewal notice stating that NYSOH did not have enough information from state and federal sources to determine if you can get help paying for your health insurance. You were directed to update your account by July 15, 2017.

On July 12, 2017, you submitted an application for financial assistance.

On July 13, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $189.00 in APTC, effective August 1, 2017. That notice also stated that you were ineligible for cost-sharing reductions, the Essential Plan, and Medicaid because your income was over the allowable income limits for those programs.

Also on July 13, 2017, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan was ending effective July 31, 2017.

On July 14, 2017, you spoke to NYSOH's Account Review Unit and appealed the level of your financial assistance.

On October 3, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) According to your NYSOH account, on your July 12, 2017 application for financial assistance, you indicated that you were married and intended to file your 2017 federal tax return with the status of married filing separately. You will claim one dependent on that tax return. You testified that information was correct.

2) You are seeking insurance for yourself.

3) You testified that you are not legally separated or divorced from your spouse, but plan on filing for divorce.

4) You testified that you have not lived with your spouse in two years.

5) You testified that your youngest child lives with you.

6) You testified that you do not plan to file a joint tax return with your spouse for 2017.

7) You testified that you will pay more than one-half of the cost of keeping up your home for 2017.

8) Your application states that your youngest child is a full-time student and is [redacted].

9) The application that was submitted on July 12, 2017 listed annual household income of $34,320.00, consisting of $34,320.00 you earn from your employment. You testified that this amount was correct.

10) You testified that your monthly income in July 2017 is the same as your current monthly income.

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

12) Your application states that you live in Richmond County.

13) You testified that you are appealing the amount of your financial assistance.

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

Applicable Law and Regulations

Medicaid Eligibility

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)).

Medicaid Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a 12-month period. This 12-month period is referred to as “continuous coverage,” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (*see* 42 CFR § 435.916(a); NY Social Services Law § 366(4)(c)).

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)).

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).

Additionally, a tax filer who is married must file a joint return with his or her spouse to qualify for APTC (45 CFR §§ 155.305(f), 155.310(d); 26 CFR § 1.36B-2).

However, an individual will be treated as not married at the close of the taxable year if the individual

1) Is legally separated from his/her spouse under a decree of divorce or of separate maintenance, or

2) Meets all of the following criteria:

    a. files a separate return from his/her spouse and maintains his/her household as the primary home for a qualifying child;

    b. pays more than one half of the cost of keeping up his/her home for the tax year; and

    c. does not have his/her spouse as a member of the household during the last six months of the tax year

(26 USC § 7703).

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).

Legal Analysis

The first issue under review is whether NYSOH properly ended your Medicaid eligibility and coverage in your Medicaid Managed Care plan, effective July 31, 2017.

On November 10, 2016, NYSOH issued a notice stating that you qualified for Medicaid, effective November 1, 2016. Also, on November 10, 2016, NYSOH issued a notice of enrollment confirmation stating that you were re-enrolled in your Medicaid Managed Care plan effective November 1, 2016.

Once individuals are determined eligible for Medicaid, they are generally guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they make to their NYSOH account. This 12-month period is based on the effective date of the Medicaid eligibility determination.

On June 18, 2017, NYSOH issued you a notice directing you to update your account by July 15, 2017, or lose your financial assistance. Based on that notice, you updated your account on July 12, 2017 to reflect an increase in your household income to $34,320.00.

The record reflects that your eligibility was redetermined based on that income amount and you were found eligible for a tax credit up to $189.00 per month. You were also determined ineligible for cost sharing reductions, the Essential Plan

and Medicaid because your household income was over the allowable income threshold.

However, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. When your Medicaid coverage terminated on July 31, 2017, the 12-month period of Medicaid eligibility that was effective on November 1, 2016, had not expired.

Therefore, the July 13, 2017 disenrollment notice stating that coverage in your Medicaid Managed Care plan would end July 31, 2017 is MODIFIED to reflect that your eligibility for and enrollment in your Medicaid Managed Care plan would continue until October 31, 2017.

The July 13, 2017, eligibility determination notice stating in relevant part that you were ineligible for Medicaid is also MODIFIED to reflect that your eligibility for and enrollment in your Medicaid Managed Care plan would continue until October 31, 2017.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and Medicaid Managed Care plan enrollment from November 1, 2016 through the end of your 12-month eligibility period, unless a disqualifying event occurs.

The second issue is whether NYSOH properly determined that you were eligible to receive up to $189.00 per month in APTC, not eligible for cost-sharing reductions and not eligible for the Essential Plan.

On July 13, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $189.00 in APTC, effective August 1, 2017.

You testified and your July 12, 2017 application reflects that you expect to file your 2017 federal income taxes as married, filing single and will claim one dependent on that tax return. You testified that you are not legally separated or divorced from your spouse, but plan on filing for divorce.

To qualify for advance premium tax credit, a person who is married must either file taxes jointly with his or her spouse or qualify as “not married” at the close of the tax year.

There is an exception, as noted above, that allows a tax filer to be treated as “not married” at the close of a taxable year, making the tax filer eligible for an advance premium tax credit.

To qualify for this exception, you must file a separate tax return from your spouse; maintain your household as the primary home for a qualifying child, must pay more than one-half of the cost of keeping up your home for the tax year, and

not have your spouse as a member of the household during the last six months of the tax year.

According to NYSOH records and your testimony at the hearing, you do not plan to file a joint federal income tax return with your spouse for the 2017 tax year, your child resides with you, you will pay more than one-half of the cost of keeping up your home for 2017 and your spouse has not been a member of the household for at least six months and you expect that to remain the case for 2017.

IMPORTANT: For you to qualify for this exception you would also have to change your application with NYSOH to reflect a tax filing status for 2017 of "head of household with a qualifying person," and your child would need to qualify as the qualifying person. For your child to be considered the qualifying person (if over the age of 19), your child must be a full-time student. Your July 12, 2017 application states that your youngest child is a full-time student and that he is [redacted].

Therefore, your case is RETURNED to NYSOH to work with you to update your application and if you choose, to change your tax filing status to a qualifying head of household based on your household income of $34,320.00 and your child being a full-time student and [redacted].

IMPORTANT: In order to avoid being without coverage you should select a plan by October 15, 2017.

Decision

The July 13, 2017 disenrollment notice stating that coverage in your Medicaid Managed Care plan would end July 31, 2017 is MODIFIED to reflect that your eligibility for and enrollment in your Medicaid Managed Care plan would continue until October 31, 2017.

The July 13, 2017, eligibility determination notice stating in relevant part that you were ineligible for Medicaid is also MODIFIED to reflect that your eligibility for and enrollment in your Medicaid Managed Care plan would continue until October 31, 2017.

Effective Date of this Decision: October 11, 2017

How this Decision Affects Your Eligibility

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and Medicaid Managed Care plan enrollment from November 1, 2016 through the end of your 12-month eligibility period, unless a disqualifying event occurs.

Your Medicaid eligibility will end effective October 31, 2017.
Your case is RETURNED to NYSOH to work with you to update your application and, if you choose, to change your tax filing status to a qualifying head of household based on your household income of $34,320.00 and your child being a full-time student and [redacted].

You will need to select a health plan by October 15, 2017, for your plan start date to be effective on November 1, 2017.

You may also need to renew your application <u>again</u>, and select a plan <u>again</u> during open enrollment for your 2018 coverage to be effective January 1, 2018.

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.

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).

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 July 13, 2017 disenrollment notice stating that coverage in your Medicaid Managed Care plan would end July 31, 2017 is MODIFIED to reflect that your eligibility for and enrollment in your Medicaid Managed Care plan would continue until October 31, 2017.

The July 13, 2017, eligibility determination notice stating in relevant part that you were ineligible for Medicaid is also MODIFIED to reflect that your eligibility for and enrollment in your Medicaid Managed Care plan would continue until October 31, 2017.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and Medicaid Managed Care plan enrollment from November 1, 2016 through the end of your 12-month eligibility period, unless a disqualifying event occurs.

Your Medicaid eligibility will end effective October 31, 2017.
Your case is RETURNED to NYSOH to work with you to update your application and, if you choose, to change your tax filing status to a qualifying head of household based on your household income of $34,320.00 and your child being a full-time student and [redacted].

You will need to select a health plan by October 15, 2017, for your plan start date to be effective on November 1, 2017.

You may also need to renew your application again, and select a plan again during open enrollment for your 2018 coverage to be effective January 1, 2018.

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)

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).