STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: January 19, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000022961

On December 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 30, 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
  PO 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(b).

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
PO Box 11729
Albany, NY 12211

Decision

Decision Date: January 19, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000022961

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that you were eligible to purchase a qualified health plan at full cost, effective October 1, 2017?

Procedural History

On October 18, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective October 1, 2016. You were subsequently enrolled in a Medicaid Managed Care (MMC) plan effective December 1, 2016.

On July 28, 2017, NYSOH issued a notice stating that additional information was required to confirm your eligibility. You were requested to submit proof of your most recent signed federal tax return by August 15, 2017.

No updates were made to your account by August 15, 2017.

On September 8, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost, effective October 1, 2017. The notice also stated that you do not meet the eligibility requirements for Medicaid. This was because your eligibility was determined by an eligibility specialist at NYSOH.

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).

Also, on September 8, 2017, NYSOH issued a disenrollment notice stating that your coverage with your MMC plan would end on September 30, 2017. This was because you were no longer eligible for Medicaid.

On September 29, 2017, you submitted two applications to NYSOH for financial assistance with your health insurance. That day, a preliminary eligibility determination was prepared, based on the last application submitted on September 29, 2017, stating that you were not eligible to receive help paying for your health insurance coverage. However, you could purchase a qualified health plan through NYSOH at full cost. This eligibility was effective as of October 1, 2017.

Also, on September 29, 2017, you spoke to NYSOH's Account Review Unit and appealed the determination that you were not eligible for Medicaid or other financial assistance.

On September 30, 2017, NYSOH issued an eligibility determination notice, based on the last September 29, 2017 application, stating that you were eligible to purchase a qualified health plan at full cost, effective October 1, 2017. The notice also stated that you did not meet the eligibility requirements for Medicaid. This was because your eligibility was determined by an eligibility specialist at NYSOH.

On October 19, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, for a limited time, effective October 1, 2017. The notice stated that you had been granted "aid to continue" until a decision is made on your appeal. You were subsequently re-enrolled in your MMC plan with a plan enrollment start date of October 1, 2017.

On December 5, 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 until December 20, 2017, to allow you to submit supporting documents.

On December 20, 2017, you uploaded to your NYSOH account, the following documents: a copy of your 2016 unsigned and undated income tax return; a copy of an investment account statement dated November 30, 2017; a copy of a one-page summary of profit and loss statement for your business for the months of September 2017, October 2017, and November 2017; and a spreadsheet showing details of the profit and loss for those same three months. Collectively those documents have been marked as Appellant's Exhibit # 1 and are incorporated into the record. 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) You testified that you are newly self-employed as the [redacted] [redacted]. You testified that your income less expenses leaves you with a net operating loss.

4) According to your September 29, 2017 application, you averaged a net income of $-3,433.33 per month for your business, and estimated a total net loss of $-41,199.96 for the year.

5) According to your September 29, 2017 application and your testimony, you are meeting your expenses through savings withdrawals.

6) According to the investment account statement dated November 30, 2017 that you submitted, you have taken withdrawals totaling $223,633.09 from a managed retirement account in 2017; nothing on the statement indicates your withdrawals from this retirement account are not fully taxable.

7) The profit and loss statement you submitted for the three-month period of September 2017, October 2017, and November 2017 indicate a net operating loss of $-19,063.68 or an average net loss of $-6,354.56 per month.

8) The copies of federal and state tax returns for 2016 were unsigned and undated, and although the returns were prepared by tax software, there is no indication that either was electronically filed, as would be required for the NY State tax return.

9) Your application states that you live in Orange County.

10) You testified that you would like to be considered eligible for Medicaid or other financial assistance for health insurance.

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

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (*see* 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities, are not an allowable deduction in computing adjusted gross income (*id.*).

Business Expenses Deduction

"Adjusted gross income" is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, deductions that are attributable to a trade or business may be deductions from a taxpayer's adjusted gross income (26 USC § 62 (a)(1)).

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 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 NYSOH 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), IRS Revenue Procedure (RP) 2016-24).

In an analysis of APTC eligibility, the determination is based on the applicable 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 federal income tax return). Those who take less tax credit in advance than they can 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)).

<u>Essential Plan</u>

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 Federal Register 8831, 8832).

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 issue is whether NYSOH properly determined that you were eligible to purchase a qualified health plan only at full cost, effective October 1, 2017.

According to your NYSOH account and your testimony, 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.

The application that was submitted on September 29, 2017 listed an annual household income of $-41,199.96.

According to your testimony, you are newly self-employed as the [redacted] [redacted]. You testified that your income less expenses leaves you with a

net operating loss. According to your September 29, 2017 application, you averaged a net income of $-3,433.33 per month and expected a total net loss of $-41,199.96 for the year. According to your September 29, 2017 application and your testimony, you are meeting your expenses through savings withdrawals.

However, according to the investment account statement for the monthly period ending November 30, 2017 that you submitted, you have taken withdrawals totaling $223,633.09 from your IRA account in the first 11 months of 2017. Extrapolated over the full 12 months of 2017, your income from this account would be $254,872.46.

The profit and loss statement you submitted for the three-month period of September 2017, October 2017 and November 2017 indicate a net operating loss of $-19,063.68 or an average net loss of -$6,354.56 per month or -$76,254.72 for the year.

Therefore, based on the information contained in the record, your estimated annual income would be $178,617.74 in 2017 ($254,872.46- $76,254.72).

It is noted that although you submitted a copy of your 2016 tax returns, that copy is of limited probative value, because the returns were undated and unsigned, and there is no sign evidence this return was the return that was filed.

An annual income of $178,617.74 is 1,503.52% of the 2016 FPL for a one-person household. Since your expected 2017 income of $178,617.74 exceeds 400% of the applicable FPL, you are not eligible for APTC through NYSOH. It is noted that even if your withdrawals from your retirement account were not extrapolated to estimate your annual income for 2017, your earnings would still be far in excess of the limit for the Medicaid program.

Cost sharing reductions are available to a person who has a household income no greater than 250% of the applicable FPL. Since a household income of $178,617.74 is 1,503.52% of the applicable 2016 FPL, you are ineligible for cost sharing reductions.

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 September 29, 2017 application, the relevant 2016 FPL was $11,880.00 for a one-person household. Since an annual household income of $178,617.74 is 1,503.52% of the 2016 FPL, you are ineligible for the Essential Plan.

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 September 29, 2017 application, the relevant FPL was $12,060.00 for a one-person household. Since $178,617.74 is 1,481.08% of the 2017 FPL, you are ineligible for Medicaid on an expected annual income basis, based on the information in the record.

As such, the September 29, 2017 eligibility determination notice is MODIFIED to state that your household income is $178,617.74 and that based on that income you are not eligible for APTC, cost-sharing reductions, the Essential Plan or Medicaid, effective October 1, 2017. The remaining portion of the September 29, 2017 eligibility determination notice stating that you are eligible to purchase a qualified health plan at full cost through NYSOH, effective October 1, 2017 is AFFIRMED.

Decision

The September 29, 2017 eligibility determination notice is MODIFIED to state that your household income is $178,617.74 and that based on that income you are not eligible for APTC, cost sharing reductions, the Essential Plan or Medicaid, effective October 1, 2017.

That portion of the September 29, 2017 eligibility determination notice stating that you are eligible to purchase a qualified health plan at full cost through NYSOH, effective October 1, 2017 is AFFIRMED.

Effective Date of this Decision: January 19, 2018

How this Decision Affects Your Eligibility

You were eligible to purchase a qualified health plan at full cost, effective October 1, 2017.

You are ineligible for APTC, cost-sharing reductions, the Essential Plan and Medicaid, effective October 1, 2017.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the

dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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
  PO Box 11729

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The September 29, 2017 eligibility determination notice is MODIFIED to state that your household income is $178,617.74 and that based on that income you are not eligible for APTC, cost sharing reductions, the Essential Plan or Medicaid, effective October 1, 2017.

That portion of the September 29, 2017 eligibility determination notice stating that you are eligible to purchase a qualified health plan at full cost through NYSOH, effective October 1, 2017 is AFFIRMED.

You were eligible to purchase a qualified health plan at full cost, effective October 1, 2017.

You are ineligible for APTC, cost-sharing reductions, the Essential Plan and Medicaid, effective October 1, 2017.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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.

(Urdu)اردو

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).