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

Notice of Decision

Decision Date: April 6, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025647

[redacted]

[redacted]

On March 19, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 13, 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: April 6, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025647

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine you were conditionally eligible to receive up to $277.00 per month in advance payments of the premium tax credit, and ineligible for Medicaid, effective January 1, 2018?

Procedural History

On December 12, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf. That day, a preliminary eligibility determination was prepared finding you eligible to receive up to $277.00 in advance payments of the premium tax credit (APTC), for a limited time, effective January 1, 2018.

Also on December 12, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you were no longer eligible for Medicaid.

On December 13, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $277.00 in APTC, for a limited time, effective January 1, 2018. The notice indicated you were not eligible for Medicaid, the Essential Plan, or cost-sharing reductions, because the annual household income you provided was over the allowable income limits for those programs. The notice directed you to submit proof of your income by March 12, 2018 to confirm your eligibility or you might lose your insurance or receive less help paying for your coverage.

On December 27, 2017, NYSOH issued a notice stating you were eligible for Medicaid for a limited time, effective January 1, 2018. This was because you had been granted Aid to Continue pending the outcome of your appeal.

Also on December 27, 2017, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2018.

On March 19, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you time to submit supporting documents.

On March 28, 2018 and March 30, 2018, NYSOH received your supporting documents by fax. The documents were incorporated into the record as Appellant's Exhibit #1 and the record was closed thereafter.

Findings of Fact

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

1) You were determined eligible for Medicaid, effective January 1, 2017, following a December 5, 2016 application listing your annual income for 2017 as $7,225.00, consisting solely of 17 unemployment insurance payments of $425.00.

2) According to your account, on October 7, 2017, NYSOH systematically redetermined your eligibility for 2018 based on income information received from state and federal data sources and found you eligible to receive up to $238.56 in APTC, effective January 1, 2018.

3) You were disenrolled from your Medicaid Managed Care plan, effective December 31, 2017.

4) On December 12, 2017, you updated your application by increasing your attested annual expected income to $34,283.66 including $28,583.66 you would earn in inconsistent income from your employment between April 9, 2018 and November 28, 2018 as well as 15 unemployment benefit payments you would receive in the amount of $380.00 each. You testified that the income information in your application was "approximately" accurate of your expected 2018 gross income.

5) You testified, and your application indicated, that you will file your 2018 tax return with a tax filing status of single and you will claim no dependents.

6) Based on the information in your December 12, 2017 application, NYSOH determined you were conditionally eligible to receive up to $277.00 per

month in APTC, effective January 1, 2018. Your eligibility was conditional upon your submission of proof of the income information listed in your application.

7) You appealed insofar as you were no longer eligible for Medicaid.

8) You were granted Aid to Continue in your Medicaid Managed Care plan pending the outcome of your appeal.

9) You testified that you have been employed seasonally at [redacted] for the past nine years.

10) You testified that [redacted] general opens in April and closes in November.

11) You testified that you received unemployment insurance benefits in the weeks that you do not work in [redacted].

12) You testified that while your income at [redacted] is inconsistent, you expect to earn approximately the same income in 2018 as you did in 2017.

13) You testified that, at the time of the hearing, you had not yet filed your 2017 tax return.

14) You testified that you cannot afford to pay the premiums for a qualified health plan in the months that you are not working.

15) You testified that in December 2017, your only income was unemployment insurance benefits you received in the gross amount of $435.00 weekly.

16) You were directed to submit proof of your income including the last pay check you received in 2017 from your employment, and a payment history report for your unemployment insurance benefits.

17) On March 28, 2017 and March 30, 2017, the Appeals Unit received the following documentation:

    a. A paystub for a check date of December 1, 2017 showing gross hourly earnings of $146.25 and cash tips received for that pay period of $576.20.

    b. A 2017 form W-2 showing gross earnings of $35,063.01 from your employment.

    c. A “Benefit Control Ledger” purportedly showing your unemployment insurance benefits. The document shows 14 payments released

between January 3, 2017 and May 3, 2017, each in the gross amount of $430.00.

i. For December 2017 the document lists four payments in the amount of $435.00 released in that month on December 4, 2017, December 11, 2017, December 18, 2017, and December 27, 2017.

18) You testified, and your application indicates, you will not be taking any deductions on your 2018 tax return.

19) Your application indicates you reside in Suffolk County.

20) At the hearing you testified that the mailing address listed on your account, [redacted] was incorrect. You testified your correct mailing address is [redacted] You were directed to contact NYSOH to correct your mailing address on file. As of the date of this decision, your address has not been updated.

21) This decision is being issued to the mailing address attested to during the hearing, [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

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is $12,060.00 for a one-person household (82 Federal Register 8831).

For annual household income in the range of at least 300% but less than 400% of the 2017 FPL, the expected contribution is 9.56 % of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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>Medicaid</u>

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).

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*.).

Legal Analysis

The issue is whether NYSOH properly determined you were conditionally eligible for up to $277.00 per month in APTC and ineligible for Medicaid, effective January 1, 2018.

The application submitted on December 12, 2017 listed annual household income of $34,283.66 including $28,583.66 you would earn from your employment in 2018 and $5,700.00 you would receive from 15 weekly unemployment insurance benefits in the amount of $380.00. Based on the information in that application, NYSOH determined you conditionally eligible to receive up to $277.00 per month in APTC, effective January 1, 2018. Your eligibility was conditional upon you submitting proof of the income information listed in your application. You appealed that determination insofar as you were no longer eligible for Medicaid.

You testified, and your application indicated, that you will file your 2018 tax return with a tax filing status of single and you will claim no dependents. You reside in Suffolk County.

You testified that you have been employed seasonally at [redacted] for the past nine years and that [redacted] generally operates from April to November.

You testified that you receive unemployment insurance benefits in the weeks that you do not work [redacted]. You testified that while your income at [redacted] is inconsistent, you expect to earn approximate the same income in 2018 as you did in 2017. According to your application, you will not take any deductions on your 2018 tax return. You testified that information was accurate.

You were directed to submit documentation of your 2017 income. On March 28, 2018 and March 30, 2018, the Appeals Unit received several documents including a 2017 form W-2 showing gross earnings of $35,063.01 from your employment, a paystub from a paycheck dated December 1, 2017 showing gross hourly earnings of $146.25 and cash tips received for that pay period of $576.20, and a "Benefit Control Ledger" purportedly showing your unemployment insurance benefits listing 14 payments released between January and April 2017 in the gross amount of $430.00 and four payments released in the month of December 2017 in the gross amount of $435.00.

Based on your testimony and the income documents submitted to the Appeals Unit, it is concluded that the record now contains sufficient evidence of your expected income for 2018. Based on your testimony that you have worked at the same employer for the last nine years and you anticipate making approximately the same income from that employment in 2018 as you did in 2017, it is concluded that the 2017 form W-2 you submitted showing you received $35,063.01 in gross income from that employment in 2017 is sufficient evidence of the income you will receive from that job in 2018.

Additionally, you testified that your employment is seasonal and that you collect unemployment insurance benefits in the weeks that you are not employed. Although your December 12, 2017 application indicated you would receive 15 unemployment insurance benefit payments in 2018 in the amount of $380.00, the documentation you submitted contradicts that information. According to the documentation, you received 18 unemployment insurance benefit payments in 2017. Furthermore, the documentation indicates that your gross weekly benefit rate from January to April 2017 was $430.00 and that the rate increased to $435.00 in December 2017. Thus, based on the documentation you submitted and your testimony that you anticipate your income in 2018 to be substantially similar to your income in 2017, it is concluded that you will receive 18 unemployment insurance benefit payments in 2018 in the gross amount of $435.00, or $7,830.00 annually.

It is further concluded that you received at least $1,886.25 in gross income in the month of December 2017, based on the documentation of the four unemployment insurance benefit payments issued in that month as well as the $146.25 in gross hourly earnings received in the December 1, 2017 paycheck. It is noted that the $576.20 in tips listed in that paystub are not included in this calculation as the evidence is insufficient to conclude that that amount was received in the month of December 2017.

Since, based on the foregoing, the evidence establishes that the December 13, 2017 eligibility determination was based on inaccurate information, that notice is RESCINDED.

It is concluded that the record now contains sufficient evidence of your expected income for 2018 as well as your monthly income for the month in which you applied. Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance with health insurance based on the record establishing you are in a one-person household with an expected annual income for 2018 of $42,893.01, including income from your employment as well as unemployment insurance benefits. Additionally, NYSOH is directed to redetermine your eligibility for Medicaid based on your monthly income as of the date of your application, pursuant to the regulations, which the evidence establishes was, at least, $1,886.25 in the month of December 2017.

Decision

The December 13, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household with an expected annual income of $42,893.01 for 2018. Additionally, NYSOH is directed to redetermine your eligibility for Medicaid based on your $1,886.25 monthly income in the month of December 2017.

Effective Date of this Decision: April 6, 2018

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 based on your testimony and the documentary evidence you submitted.

You will receive an updated written determination of your eligibility from NYSOH.

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 case 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
P.O. Box 11729
Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The December 13, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household with an expected annual income of $42,893.01 for 2018. Additionally, NYSOH is directed to redetermine your eligibility for Medicaid based on your $1,886.25 monthly income in the month of December 2017.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility based on your testimony and the documentary evidence you submitted.

You will receive an updated written determination of your eligibility from NYSOH.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई 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).