



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

Notice of Decision

Decision Date: July 22, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000007075



Dear [REDACTED]

On June 27, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's February 13, 2016 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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NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000007075



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 not eligible for financial assistance, effective March 1, 2016?

Procedural History

On February 12, 2016, NYSOH received your completed application for health insurance.

On February 13, 2016, NYSOH issued an eligibility determination notice based on the information contained in the February 12, 2016 application, stating that you were newly eligible to enroll in a qualified health plan (QHP) at full cost. The notice also stated that you were not eligible to receive advance payments of the premium tax credit (APTC), cost-sharing reductions (CSR), or coverage under the Essential Plan or Medicaid. This eligibility determination was effective March 1, 2016.

Also on February 13, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the February 13, 2016 eligibility determination notice insofar as you were found ineligible for financial assistance at that time.

On June 27, 2016, 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.

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Findings of Fact

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

- 1) You testified, and your application reflects, that you are 66 years old and not a parent or caretaker of relative of dependent child.
- 2) You testified, and your application reflects, that you expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.
- 3) You are seeking insurance for only yourself.
- 4) The application that was submitted on February 12, 2016 listed annual household income of \$7,887.72, which consisted of \$7,205.00 taxable income from a trust you expected to receive during 2016, and \$682.72 in taxable interest you expected to receive during 2016.
- 5) You testified, however, that the figure you provided to the NYSOH was not accurate, and that you actually expected to receive approximately \$3,000.00 per month during 2016 in taxable trust income you expect to receive and \$1,400.00 per month in taxable pension and annuity income.
- 6) Your application states that you will not be taking any deductions on your 2016 tax return.
- 7) You live in Ulster County, New York.
- 8) You testified that you were seeking tax credits in paying for health insurance through NYSOH since you are not eligible for Medicare. You further testified that you did not wish to be referred to your Local Department of Social Services since you believed you would not be eligible for Medicaid as they would consider your assets in making a determination.

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 (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 200% and 400% of the applicable federal

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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)).

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 2015 FPL, which is \$11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

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).

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 2015 FPL, which is \$11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

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

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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 2015 FPL, which is \$11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were ineligible for financial assistance, effective March 1, 2016.

The application that was submitted on February 12, 2016 listed an annual household income of \$7,887.72, which consisted of \$7,205.00 taxable income from a trust you expected to receive during 2016, and \$682.72 in taxable interest you expected to receive during 2016. The eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2016 income taxes as single and will claim no dependents on that tax return.

APTC is available to a person who has a household income between 200% and 400% of the FPL. Since a household income of \$7,887.72 is 67.02% of the applicable FPL, NYSOH correctly found you to be ineligible for APTC.

CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of \$7,887.72 is 67.02% of the applicable FPL, NYSOH correctly found you to be ineligible for CSR.

The Essential Plan is 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 (MAGI) that is between 138% and 200% of the FPL for the applicable family size. Since the credible evidence of record reflects that on the date of your application you were 65 years old. Therefore, NYSOH correctly found you to be 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 (MAGI) that is at or below 138% of the FPL for the applicable family size. On the date of your application, the credible evidence of record reflects that you were 65 years old. Therefore, NYSOH correctly found you to be ineligible for Medicaid.

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Since the February 13, 2016 eligibility determination properly stated that, based on the information you provided in your February 12, 2016 application, you were ineligible for APTC, CSR, the Essential Plan, and Medicaid, it is correct and is **AFFIRMED**.

However, at the hearing you testified that your annual household income is different than what was attested to in your application on February 12, 2016. You testified that the taxable portion of your income is more accurately represented as you receiving \$3,000.00 per month during 2016 in taxable trust income you expect to receive and \$1,400.00 per month in taxable pension and annuity income.

Based upon the additional information you provided during the hearing, you now expect to receive approximately \$52,800.00 in income during 2016. APTC is available to a person who has a household income between 200% and 400% of the FPL. Since a household income of \$52,800.00 is 448.60% of the applicable FPL, you would still be ineligible for APTC. Therefore, the record does not support a return of your case for a redetermination of your eligibility at this time.

Decision

The February 13, 2016 eligibility determination notice is **AFFIRMED**.

Effective Date of this Decision: July 22, 2016

How this Decision Affects Your Eligibility

You remain eligible to enroll in a QHP at full cost.

You are ineligible for APTC, CSR, the Essential Plan and Medicaid.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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.

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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 U.S. Department of Health and Human Services. 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 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 February 13, 2016 eligibility determination notice is AFFIRMED.

You remain eligible to enroll in a QHP at full cost.

You are ineligible for APTC, CSR, the Essential Plan and Medicaid.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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