



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

Notice of Decision

Decision Date: August 03, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000007430

[REDACTED]

Dear [REDACTED],

On August 1, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's February 27, 2016 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 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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Decision

Decision Date: August 03, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000007430

[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 that you were not eligible to receive financial assistance through NYSOH?

Procedural History

On February 26, 2016, NYSOH received a revised application in which you attested to being born on [REDACTED]. You also attested to an expected yearly income of \$0.00.

On February 27, 2016, NYSOH issued an eligibility determination notice based on the information contained in the February 26, 2016 application. It stated that you were eligible to purchase a qualified health plan (QHP) through NYSOH at full cost. The notice also stated that you were not eligible for advance premium tax credits (APTC), cost-sharing reductions (CSR), the Essential Plan or Medicaid. This eligibility determination was effective April 1, 2016. You appealed this eligibility determination insofar as you were found not eligible for financial assistance through NYSOH.

On August 1, 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.

Findings of Fact

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

- 1) You turned 65 years old on [REDACTED].
- 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 testified, and your application reflects, that you are a widow and immigrant non-citizen permanently residing in the United States. You further testified that you have been in the U.S. since about 2003 and will be going through the naturalization process shortly.
- 4) The application that was submitted on February 26, 2016 listed an expected household income of \$0.00. You testified that this amount was correct, and you rely solely upon your family for financial assistance.
- 5) You testified that during 2015 you were enrolled in a buy-in program for Medicare through the Social Security Administration (SSA) at an approximate premium of \$140.00 per month, until December 31, 2015 when you were disenrolled. You further testified you were enrolled in Medicare Part D until that time as well.
- 6) You testified that you attempted to access health insurance through your local Department of Social Services (LDSS), but were turned away.
- 7) You testified that you were seeking financial assistance through NYSOH in order to afford a health plan to see the doctor in connection with your breathing difficulties.
- 8) You live in Westchester County, New York.

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

Applicable Law and Regulations

Advance Premium Tax Credit

The APTC is available to a person who is eligible to enroll in a QHP and (1) expects to have a household income between 200% and 400% of the applicable 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

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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), 45 CFR § 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).

Medicaid

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

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(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (see N.Y. Soc. Serv. Law § 366(1)(c)).

Legal Analysis

The sole issue under review is whether NYSOH properly determined that you were not eligible to receive financial assistance to help pay for the cost of health insurance coverage through NYSOH.

The application that was submitted on February 26, 2016 reflected that you were 69 years old as of the date of your application, and had an annual household income of \$0.00. 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 greater than 200%, but no greater than 400%, of the FPL. Since a household income of \$0.00 is 0.00% of the applicable FPL, NYSOH correctly found you to be ineligible for APTC.

CSR is available to a person who is eligible for APTC and has a household income no greater than 250% of the FPL. Since you were found ineligible for APTC, you are also ineligible for CSR.

The Essential Plan is provided through NYSOH to legally present immigrant non-citizens who meet the non-financial requirements, such as being under 65 years old, and have a household modified adjusted gross income (MAGI) that is between 0% and 200% of the FPL for the applicable family size. Since you were 69 years old on the date of your application, which was February 26, 2016, you were correctly found 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. Since the record reflects that you were 69 years old on the date of your application, you are not eligible for Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI-based Medicaid. Since you may be eligible for Medicaid on a non-MAGI

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basis, NYSOH will refer your case to the Westchester County LDSS for consideration.

Westchester County LDSS will determine your eligibility for Medicaid on a non-MAGI basis.

Decision

The February 27, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: August 03, 2016

How this Decision Affects Your Eligibility

You do not qualify for APTC, CSR, the Essential Plan or MAGI-based Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI Medicaid.

NYSOH will refer your case to the Westchester County LDSS for consideration on your eligibility for non-MAGI 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.

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)).

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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 27, 2016 eligibility determination notice is AFFIRMED.

You do not qualify for APTC, CSR, the Essential Plan or MAGI-based Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI Medicaid.

NYSOH will refer your case to the Westchester County LDSS for consideration on your eligibility for non-MAGI Medicaid.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

