



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

Notice of Decision

Decision Date: January 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000011344

[REDACTED]

[REDACTED]

On December 29, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's August 5, 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 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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Decision

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NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000011344

[REDACTED]

Issues

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

Did NY State of Health (NYSOH) properly determine that you were not eligible for financial assistance as of the August 5, 2016 notice of eligibility determination?

Procedural History

On July 25, 2016, NYSOH received your completed application for health insurance.

On July 26, 2016, NYSOH issued a notice stating that you might be eligible for health insurance; however, more information was needed to make a determination. The notice directed you to provide income documentation by August 9, 2016 to confirm the information in your account was accurate so that an appropriate determination could be made. The notice gave instructions that if you needed to document NYS Unemployment Benefits, you could do this with:

- Award letter/certificate
- Monthly benefit statement from NYS Department of Labor
- Printout of recipient's account information from NYS Department of Labor's website
- Copy of Direct Payment Card with statement
- Letter from the NYS Department of Labor with your reason for denial

On July 29, 2016, NYSOH received an Unemployment Insurance Monetary Benefit Determination issued to you on June 29, 2016, which stated that this was

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not a decision on your eligibility for Unemployment benefits. However, it confirmed that if you did qualify for such benefits, your weekly rate would be \$425.00 per week, based on your earnings history.

On August 4, 2016, NYSOH redetermined your eligibility determination based on information contained in your account as of August 4, 2016.

On August 5, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan (QHP) at full cost through NYSOH, effective September 1, 2016, based on annual earnings of \$96,050.00. The notice further stated that you were not eligible for advance payments of the premium tax credit (APTC), cost-sharing reductions (CSR), or Medicaid.

On August 9, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the August 5, 2016 eligibility determination notice insofar as you were not found eligible for Medicaid.

On December 29, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: a screenshot of your Unemployment Benefits History reflecting all unemployment benefits received by you during the month of July 2016. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier.

That same day, you provided the above referenced document to the Appeals Unit through NYSOH account.

Accordingly, the record was closed on December 29, 2016.

Findings of Fact

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

- 1) You testified that you expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.
- 2) You are seeking insurance for yourself only.
- 3) The application that was submitted on July 25, 2016 listed annual household income of \$85,000.00, consisting solely of income you earned from your former employer, [REDACTED] [REDACTED] between January 1, 2016 and June 24, 2016. You testified that this amount was correct.

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- 4) On July 29, 2016, you provided to NYSOH a screenshot of an Unemployment Insurance Monetary Benefit Determination issued to you on June 29, 2016, confirming your unemployment claim against [REDACTED] and your award of a \$425.00 per week unemployment benefit rate.
- 5) You were found eligible to enroll in a QHP at full cost, effective September 1, 2016. You were further found not to be eligible for financial assistance.
- 6) You testified, and provided documentation, that your monthly income during the month of your application, July 2016, was \$1,275.00, which consisted of three benefit payments of \$425.00.
- 7) Your application reflected that you will not be taking any deductions on your 2016 tax return.
- 8) You live in Nassau County, New York.
- 9) You testified that as a result of not being found eligible for Medicaid after you were laid off from your position at [REDACTED] on June 24, 2016, you were unable to afford health insurance through NYSOH.
- 10) You testified that you were forced to enroll in COBRA coverage offered by Hewlett Packard, which cost approximately \$500.00 per month. In addition to seeking to be found eligible for Medicaid coverage, you were interested in having your COBRA premiums reimbursed if you were found eligible for Medicaid as a result of your appeal.

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 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)).

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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 Federal Register 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)).

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 2016, which is \$11,880.00 for a one-person household (81 Fed. Reg. 4036).

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 under review is whether NYSOH properly determined that you were ineligible for financial assistance as of your July 25, 2016 application.

The application that was submitted on July 25, 2016 listed an annual household income of \$85,000.00 and the eligibility determination. You later provided documentation reflecting that your position with [REDACTED] ended on June 24, 2016. Your eligibility for financial assistance was redetermined by NYSOH

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as a result of this additional information you provided. NYSOH relied upon that information in issuing its determination.

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.

Advance payments of the premium tax credits (APTC) are available to a person who has a household income greater than 138% of the FPL and no greater than 400% of the FPL. Since a household income of \$85,000.00 is 722.18% of the applicable FPL, NYSOH correctly found you to be ineligible for APTC.

Cost-sharing reductions (CSR) are available to a person who has a household income no greater than 250% of the FPL. Since a household income of \$85,000.00 is 722.18% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

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 relevant FPL was \$11,880.00 for a one-person household. Since \$85,000.00 is 715.49% of the 2016 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the August 5, 2016 eligibility determination notice properly stated that, based on the information you provided, you were not eligible for financial assistance, it is correct and is AFFIRMED.

However, financial eligibility for Medicaid for applicants is based on current monthly household income and family size, not on annual earnings.

The Unemployment Insurance Monetary Benefit Determination issued to you on June 29, 2016 was insufficient to determine your monthly earnings, because it did not provide the specific payments made to you in the month of your application.

The Appeals Unit finds that you reasonably believed that the Unemployment Insurance Monetary Benefit Determination you submitted would comply with the July 26, 2016 notice to you, and that the notice itself failed to properly identify the nature of the needed documentation.

At the direction of the Hearing Officer, you provided a copy of your Unemployment Benefits History reflecting that you received three unemployment insurance payments of \$425.00 during July 2016. Accordingly, your monthly income during July 2016 was \$1,275.00.

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To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,366.00 per month. Since the documentation you provided shows that you received only \$1,275.00 during July 2016, there is sufficient evidence to return your application to NYSOH to determine whether you were eligible for Medicaid based on your monthly income during July 2016.

Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid based on a one-person household in Nassau County with an income of \$1,275.00 during July 2016.

The Appeals Unit has no authority to direct any reimbursement of premiums from insurance not obtained through NYSOH.

However, NYSOH is further directed to assist you in determining whether you have any avenues to request reimbursement of your COBRA premiums.

Decision

The August 5, 2016 eligibility determination notice is AFFIRMED.

However, your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid based on a one-person household in Nassau County with an income of \$1,275.00 during July 2016. NYSOH is further directed to assist you in determining whether you have any avenues to request reimbursement of your COBRA premiums, should you be found eligible for Medicaid.

Effective Date of this Decision: January 18, 2017

How this Decision Affects Your Eligibility

You are not eligible for either APTC or CSR.

You will be receiving a new eligibility determination shortly on your eligibility for Medicaid based on your monthly income during July 2016.

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)).

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 August 5, 2016 eligibility determination notice is **AFFIRMED**.

However, your case is **RETURNED** to NYSOH to redetermine your eligibility for Medicaid based on a one-person household in Nassau County with an income of \$1,275.00 during July 2016. NYSOH is further directed to assist you in

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determining whether you have any avenues to request reimbursement of your COBRA premiums, should you be found eligible for Medicaid.

You are not eligible for either APTC or CSR.

You will be receiving a new eligibility determination shortly on your eligibility for Medicaid based on your monthly income during July 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

