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

Notice of Decision

Decision Date: April 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012915

[redacted]

Dear [redacted],

On February 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 29, 2016 eligibility redetermination 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012915

[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 your family was not eligible to receive advance payments of the premium tax credit (APTC), effective December 1, 2016?
>
> Did NYSOH properly determine that your family was not eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that your family was not eligible for Medicaid?

Procedural History

On October 28, 2016, NYSOH issued a preliminary eligibility determination stating that your family was eligible to purchase a qualified health plan (QHP) at full cost and ineligible to receive help paying for your health insurance coverage, effective December 1, 2016.

That same day, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your family was denied financial assistance.

On October 29, 2016, NYSOH issued an eligibility determination notice based on the information contained in your October 28, 2016 application, stating that your family was eligible to purchase a QHP at full cost, effective December 1, 2016.

On December 27, 2016, you submitted a copy of your Unemployment Benefit Payment Record (*see* Document [redacted]).

On February 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open until March 10, 2017 for you to submit proof of your household income for October 2016, November 2016 and December 2016.

On March 13, 2017, you submitted your spouse's paystubs for those three months and although the documentation was received late, in the interest of justice, the Hearing Officer accepted them. These documents were made part of the record as "Appellant's Exhibit A." The record is now closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you expect to file your 2016 and 2017 taxes with a tax filing status of married filing jointly. You will claim two dependents on those tax returns.

2) You are seeking insurance for your family.

3) The application that was submitted on October 28, 2016 listed annual household income of $139,041.00, consisting of $113,353.00 you earned from your employment and unemployment benefits and $25,688.00 your spouse earns from her employment. You testified these amounts were correct.

4) You testified, and submitted documentation to show that, in August 2016, you lost your job but continued to receive pay from your employer in September 2016, including a final check dated September 13, 2016 in the amount of $9,288.00.

5) According to your Unemployment Benefit Payment Record, you began receiving unemployment benefits on September 11, 2016.

6) According to your NYSOH account and your testimony, you will not be taking any deductions on your 2016 tax return.

7) On December 27, 2016, you submitted a copy of your Unemployment Benefit Payment Record, which indicates that you were paid unemployment benefits of $2,145.00 in October 2016, $1,720.00 in

November 2016, and $1,720.00 in December 2016 (*see* Document [redacted]).

8) On March 13, 2017, you submitted your spouse's paystubs reflecting that she was paid $2,430.56 in October 2016, $2,501.36 in November 2016, and $3,599.in December 2016 from employment.

9) Combining your incomes and benefits received during these months totals household income as follows:

    a) October 2016: $2,145.00 + $2,430.56 = $4,575.56.
    b) November 2016: $1,720.00 + $2,501.36 = $4,221.36
    c) December 2016: $1,720.00 + $3,599.20 = $5,319.20.

    (*see* Appellant's Exhibit A).

10) You testified that you are seeking an exemption from the IRS penalty through this appeal.

11) According to your NYSOH account and your testimony, you live in [redacted] New York.

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)).

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 applications, that was the 2015 FPL, which is $24,250.00 for a four-person household (80 Federal Register 3236, 3237).

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).

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 applications, that was the 2016 FPL, which is $24,300.00 for a four-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).

People who receive or are eligible for Medicaid are not eligible for APTC since they have, or will soon have, active coverage in the system. They will be enrolled or remain in their Medicaid plan for 12 months, with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, failing to provide a valid Social Security number, or having third party health insurance (N.Y. Soc. Serv. Law § 366(4)(c)).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your family was ineligible for APTC as of December 1, 2016.

The application that was submitted on October 28, 2016 listed an annual household income of $139,041.00 and the eligibility determination relied upon that information.

You are in a four-person household for purposes of this analysis. This is because you expect to file your 2016 income taxes as married filing jointly and will claim two dependents on that tax return.

APTC is available to a person who has a household income no greater than 400% of the FPL. In an evaluation for eligibility in 2016, an annual income of $139,041.00 is 573.36% of the 2015 FPL of $24,250.00 for a four-person household.

Since a household income of $139,041.00, which you attested to in your October 28, 2016 application, is 573.36% of the applicable FPL for 2016 for a four-person household, NYSOH correctly found your family to be ineligible for APTC, effective December 1, 2016.

The second issue under review is whether your family was properly found ineligible for cost-sharing reductions.

Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL and are eligible to receive APTC. Since a household income of $139,041.00 is 573.36% of the applicable FPL and your family was determined in eligible for APTC, NYSOH correctly found your family to be ineligible for cost sharing reductions, effective December 1, 2016.

The third issue under review is whether NYSOH properly determined that your family was ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65, and to children between the age of 1 and 19, who meet the non-financial

requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% and 154% of the FPL, respectively, for the applicable family size.

On the date of your October 28, 2016 application, the relevant FPL was $24,300.00, Since $139,041.00 is 572.19% of the 2016 FPL for adults and children, NYSOH properly found your family to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

On December 27, 2016 and March 13, 2017, you submitted proof of your household income reflecting that for the months of October 2016 through December 2016 your family's household income was as follows:

d) October 2016: $2,145.00 + $2,430.56 = $4,575.56.
e) November 2016: $1,720.00 + $2,501.36 = $4,221.36
f) December 2016: $1,720.00 + $3,599.20 = $4,221.36

(*see* Document [redacted] and Appellant's Exhibit A).

To be eligible for Medicaid, your family would need to meet the non-financial criteria and have an income no greater than 138% and 154% of the applicable FPL for an adult and a child in 2016, which is $2,795.00 and $3,119.00 per month, respectively. Since the record supports that your household income was $4,575.56, $4,221.36, and $4,221.36 in October 2016, November 2016, and December 2016, in that order, your family does not qualify for Medicaid based on monthly income as of the date of your application.

Since the October 29, 2016 eligibility redetermination notice properly stated that, based on the information you provided, your family was ineligible for APTC, ineligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and must be AFFIRMED.

During the hearing, you testified that you are concerned about receiving a tax penalty as a result of being without coverage.

Sometimes after an appeal decision, an appellant can claim an exemption from the requirement to have health insurance. You might qualify for a health coverage exemption in 2016 if you didn't have health coverage while you were waiting for an appeal decision about coverage eligibility or savings ***and*** your appeal was eventually successful (emphasis added).

You must claim this exemption through the United States Department of Health and Human Services (HHS). Currently, NYSOH does not accept hardship exemption applications.

You will find the information you need to claim the exemption due to an appeal decision at https://www.healthcare.gov/exemptions-tool/#/results/2016/details/eligible-based-on-appeal. You can also call 1-800-318-2596.

Important: If you do not get a response from HHS to your exemption application in time to file your tax return, write the word "pending" in column "c" and file your return. If HHS does not approve your exemption, you will need to file an amended return later.

Decision

The October 29, 2016 eligibility redetermination notice is AFFIRMED.

This Decision has no effect on any subsequent eligibility redeterminations or enrollment notices issued by NYSOH.

Effective Date of this Decision: April 10, 2017

How this Decision Affects Your Eligibility

Your family was ineligible for APTC in December 2016.

Your family was ineligible for cost-sharing reductions in December 2016.

Your family was ineligible for Medicaid as of December 1, 2016.

This decision does not affect your family's current eligibilities or enrollments.

If You Disagree with this Decision (Appeal Rights)

This 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 October 29, 2016 eligibility redetermination notice is AFFIRMED.

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 Decision has no effect on any subsequent eligibility redeterminations or enrollment notices issued by NYSOH.

Your family was ineligible for APTC in December 2016.

Your family was ineligible for cost-sharing reductions in December 2016.

Your family was ineligible for Medicaid as of December 1, 2016.

This decision does not affect your family's current eligibilities or enrollments.

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)

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).

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।

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.

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.

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(Yiddish) אידיש

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).