



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

Notice of Decision

Decision Date: March 30, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013289

[REDACTED]

Dear [REDACTED]

On February 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 16, 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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Decision Date: March 30, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013289

[REDACTED]

Issues

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

Did NY State of Health properly determine that your eldest adult child (Marketplace ID [REDACTED]) was eligible to receive \$0.00 per month in advance payments of the premium tax credit, effective December 1, 2016?

Did NY State of Health properly determine that the same adult child was eligible for cost-sharing reductions, effective December 1, 2016?

Did NY State of Health properly determine that the same adult child was not eligible for Medicaid?

Procedural History

On September 6, 2016, NY State of Health (NYSOH) issued a notice that your eldest adult child's Medicaid coverage through the [REDACTED] Department of Social Services would end on November 30, 2016. That notice stated that you needed to update your account by November 15, 2016 or your adult child's health coverage might end.

On November 15, 2016, NYSOH received your updated application for health insurance.

That day, a preliminary eligibility determination was prepared finding in relevant part that your eldest adult child (adult child) was eligible for a tax credit of \$0.00

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per month to help pay for his health coverage. It further stated that he was eligible for cost sharing reductions if he selected a silver-level qualified health plan. This eligibility was effective as of December 1, 2016.

Also on November 15, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the \$0.00 level of your adult child's advance payments of the tax credit (APTC) and his eligibility for Medicaid.

On November 16, 2016, NYSOH issued an eligibility redetermination notice based on the information contained in the November 15, 2016 application, stating in relevant part that your adult child was eligible to receive \$0.00 per month in APTC and, if you selected a silver-level qualified health plan for him, for cost-sharing reductions. This eligibility was effective December 1, 2016.

On February 14, 2017, 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

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 married filing jointly. You will claim eleven dependents on that tax return.
- 2) You are seeking insurance for your eldest adult child, whose date of birth is [REDACTED] and who has been assigned Marketplace ID # [REDACTED]. He was [REDACTED] old at all times relevant.
- 3) The application that was submitted on November 15, 2016 listed annual household income of \$131,000.00. Per your testimony, this consisted of your spouse's income of \$50,000.00 from the [REDACTED] \$60,000.00 from [REDACTED] and \$18,000.00 from [REDACTED]. You testified that you earn \$3,000.00 from [REDACTED]. You testified that the total amount was correct.
- 4) Your application states that you will not be taking any deductions on your 2016 tax return.
- 5) Your application states that you and your family live in Rockland County, New York.

- 6) You testified that your children have all been on Medicaid and you are not sure why your one adult child is not eligible for Medicaid also now.

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)).

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 2016 is set by federal law at 2.03% to 9.66% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37).

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 \$61,690.00 for a thirteen-person household (80 Federal Register 3236, 3237).

For annual household income in the range of at least 200% but less than 250% of the 2015 FPL, the expected contribution in 2016 is between 6.41% and 8.18%

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of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37.

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 application, that at 100% of the 2016 FPL is \$61,690.00 for a thirteen-person household (81 Fed. Reg. 4036).

Legal Analysis

The first issue is whether NYSOH properly determined that your adult child was eligible for an APTC of \$0.00 per month.

The application that was submitted on November 15, 2016, listed an annual household income of \$131,000.00 and the eligibility determination relied upon that information.

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Your adult child is in a thirteen-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 eleven dependents on that tax return.

You and your family reside in Rockland County, where the second lowest cost silver plan available for an individual through NYSOH costs \$394.37 per month.

An annual income of \$131,000.00 is 212.35% of the 2015 FPL of \$61,690 for a thirteen-person household. At 212.35% of the FPL, the expected contribution in 2016 to the cost of the health insurance premium is 6.85% of income, or \$747.79 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county (\$394.37 per month) minus your expected contribution (\$747.79 per month), which equals \$-353.42 per month. Therefore, because your monthly contribution exceeds the amount of APTC by \$353.42, NYSOH correctly determined your adult child to be eligible for \$0.00 per month in APTC.

The second issue is whether your adult child was properly found eligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of \$131,000.00 is 212.35% of the applicable FPL, NYSOH correctly found your adult child to be eligible for cost sharing reductions.

The third issue is whether NYSOH properly determined that your adult child was ineligible for Medicaid.

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 \$61,690.00 for a thirteen-person household, which at 138% equals \$85,133.00. Since \$131,000.00 is 212.35% of the 2016 FPL and exceeds the maximum allowable income limit of \$85,133.00, NYSOH properly found your adult child to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the November 16, 2016, eligibility redetermination notice properly stated that, based on the information you provided, your adult child was eligible for \$0.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The November 16, 2016 eligibility redetermination notice is AFFIRMED.

Effective Date of this Decision: March 30, 2017

How this Decision Affects Your Eligibility

Your adult child was eligible for \$0.00 per month of APTC during December 2016.

Your adult was eligible for cost-sharing reductions during December 2016.

Your adult child was ineligible for Medicaid as of the November 16, 2016 eligibility redetermination notice.

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

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).

- 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):

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- 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 November 16, 2016 eligibility redetermination notice is AFFIRMED.

Your adult child was eligible for \$0.00 per month of APTC during December 2016.

Your adult was eligible for cost-sharing reductions during December 2016.

Your adult child was ineligible for Medicaid as of the November 16, 2016 eligibility redetermination notice.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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।

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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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bεtumi ama wo obi a okyerε kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.

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