



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

Notice of Decision

Decision Date: June 1, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014041

[REDACTED]

Dear [REDACTED],

On May 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 14, 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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NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014041



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 eligible to receive up to \$501.00 per month in advance payments of the premium tax credit (APTC), effective January 1, 2017?

Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?

Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On October 24, 2015, NYSOH issued a renewal notice stating that you were eligible for Medicaid as of January 1, 2016.

On December 4, 2015, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid but that your coverage would continue until December 31, 2016 because certain individuals who were found eligible for Medicaid will have their coverage continue for 12 continuous months.

On October 15, 2016 NYSOH issued a renewal notice stating that there was not enough information from state and federal sources to determine if you qualified for financial assistance for the upcoming coverage year, you were asked to update your account between November 16, 2016 and December 15, 2016.

On November 25, 2016, you submitted an application for financial assistance.

On November 26, 2016, NYSOH issued a notice of eligibility determination stating you were eligible to receive up to \$501.00 in APTC and ineligible for cost-sharing reductions effective January 1, 2017. The notice also stated you were ineligible for cost sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid because the household income you provided was over the allowable income limits for those programs.

On November 28, 2016, NYSOH issued an enrollment notice stating your Medicaid Managed Care plan would end effective December 31, 2016.

On December 13, 2016, you submitted an application for financial assistance.

On December 14, 2016, NYOSH issued a notice of eligibility determination stating you were eligible to receive up to \$501.00 in APTC and ineligible for cost-sharing reductions effective January 1, 2017. The notice also stated you were ineligible for cost sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid because the household income you provided was over the allowable income limits for those programs.

On December 14, 2016, an enrollment notice was issued confirming your enrollment in a Gold level qualified health plan effective January 1, 2017.

On December 15, 2016, you spoke to NYSOH's Account Review Unit and appealed the determination notice finding you eligible for APTC and no longer eligible for Medicaid. You also requested Aid to Continue for the duration of your appeal.

On January 6, 2017, NYSOH issued a notice stating you were eligible for Medicaid for a limited time. You have been granted Aid to Continue until a decision is made on your appeal. The determination was effective January 1, 2017.

Also on January 6, 2017, an enrollment notice was issued stating you were enrolled in a Medicaid Managed Care plan starting January 1, 2017.

On March 15, 2017 you were scheduled to appear at telephone hearing. However, the telephone hearing was adjourned to a later date.

On May 3, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open up to May 18, 2017, to allow you to submit supporting documents.

As of May 18, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was

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closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

- 1) You are seeking insurance for yourself.
- 2) You are seeking to be found eligible for Medicaid.
- 3) The application that was submitted on December 13, 2016 listed annual household income of \$51,000.00 consisting of \$36,000.00 you earn from your employment and \$15,000.00 your spouse receives in earned income. You testified that this amount was correct.
- 4) You testified you were pregnant at the time of your December 13, 2016 application. That application states that you will be filing your taxes with a tax filing status of married filing jointly.
- 5) You gave birth on [REDACTED].
- 6) Your application states that you will not be taking any deductions on your 2017 tax return.
- 7) Your application states that you live in Kings County.

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:

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- 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 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

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 2016 FPL, which is \$16,020.00 for a two-person household (81 Federal Register 4036).

For annual household income in the range of at least 300% but less than 400% of the 2017 FPL, the expected contribution is between 9.69% and 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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)).

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the federal poverty level (FPL) for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

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 FPL, which is \$20,160.00 for a three-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).

Household Composition

For purposes of advance premium tax credit (APTC) and cost-sharing reductions (CSR), the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

For purposes of Medicaid eligibility, however, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to \$501.00 per month.

The application that was submitted on December 13, 2016 listed an annual household income of \$51,000.00 and the eligibility determination relied upon that information.

You are in a two-person household for purposes of APTC at the time of your application. Although you were pregnant, your household only consisted of yourself, your spouse and no current dependents as of the December 13, 2016 application date.

You reside in Kings County, where the second lowest cost silver plan available for a couple through NYSOH costs \$912.91 per month.

An annual income of \$51,000.00 is 318.35% of the 2016 Federal Poverty Level (FPL) for a two-person household. At 318.35% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or \$411.82 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 (\$912.91 per month) minus your expected contribution (\$411.82 per month), which equals \$501.09 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$501.00 per month in APTC.

The second issue is whether you were 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. Since a household income of \$51,000.00 is 318.35% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the federal poverty level (FPL) for the applicable family size. For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver

On the date of your application, the relevant FPL was \$20,160.00 for a three-person household. Since \$51,000.00 is 252.97% 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.

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

The Hearing Officer allowed the record to remain opened up to 15 days after your telephone hearing. At the close of the record, the NYSOH Appeals Unit did not receive your additional documentation, as such a decision on your eligibility for Medicaid can only be determined based upon the information in your application and your testimony on the date of your hearing.

Since the December 14, 2016 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$501.00 per month in APTC, ineligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The December 14, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: June 1, 2017

How this Decision Affects Your Eligibility

You remain eligible for up to \$501.00 in APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for Medicaid.

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

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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 December 14, 2016 eligibility determination notice is **AFFIRMED**.

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You remain eligible for up to \$501.00 in APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for 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:



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 مجاناً.

বাংলা (Bengali)

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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 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&tumi ama wo obi a okyerE 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.

שׂוּדִישׁ (Yiddish)

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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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