



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

Notice of Decision

Decision Date: May 10, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014786

[REDACTED]

Dear [REDACTED],

On April 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 6, 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 Date: May 10, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014786



Issues

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

Did NY State of Health properly determine that you were eligible to receive up to \$15.00 per month in advance payments of the premium tax credit, effective January 1, 2017?

Did NY State of Health properly determine that you were eligible for cost-sharing reductions?

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

Did NY State of Health properly determine that your youngest child was eligible for Child Health Plus with a \$15.00 monthly premium, effective January 1, 2017?

Did NY State of Health properly determine that your youngest child was ineligible for Medicaid?

Procedural History

On December 5, 2016, NY State of Health (NYOSH) received your updated application for financial assistance with health insurance.

On December 6, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$15.00 in advanced premium tax credits

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(APTC), eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, and your youngest child was eligible for Child Health Plus with a \$15.00 monthly premium, effective January 1, 2017. That notice further directed you to submit household income documentation for your youngest son by January 8, 2017, and for you by February 7, 2017 in order to confirm the information that was in your application was accurate.

Also on December 6, 2016, NYSOH issued a plan enrollment notice confirming your youngest child's enrollment in his Child Health Plus plan with a \$15.00 monthly premium, effective June 1, 2016.

Also on January 11, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you and your youngest child were not eligible for a higher level of financial assistance.

On April 7, 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 are seeking insurance for yourself and your youngest child.
- 2) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim three dependents on that tax return.
- 3) The application that was submitted on December 5, 2016 listed annual household income of \$67,640.24, consisting of income your spouse earns from his employment.
- 4) You testified, and provided documentation to show, that your monthly household income for December 2016 was \$6,250.00.
- 5) Your application states that you will not be taking any deductions on your 2017 tax return.
- 6) Your application states that you live in Suffolk County, NY.

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 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 \$28,440.00 for a five -person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution for 2017 is between 6.43% and 8.21% 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

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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 was the 2016 FPL, which is \$28,440.00 for a five-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).

Child Health Plus

Child Health Plus (CHP) is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (see New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be “eligible

for medical assistance”; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child’s family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from \$9.00 per month to \$60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is \$9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than \$27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

The CHP premium is \$15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than \$54.00 per month per family (NY PHL § 2510(9)(d)(iii)).

In an analysis of Child Health Plus 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 was \$28,440.00 for a five -person household (80 Federal Register 3236, 3237).

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 FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

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 was \$28,440.00 for a five-person household (81 Federal Register 4036).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to \$15.00 per month.

The application that was submitted on December 5, 2016 listed an annual household income of \$67,640.04 and the eligibility determination relied upon that information.

You are in a five-person household for purposes of this analysis. This is because you expect to file your 2017 income taxes as married filing jointly and will claim three dependents on that tax return.

You reside in Suffolk County, where the second lowest cost silver plan available for an individual through NYSOH costs \$453.36 per month.

An annual income of \$67,640.04 is 237.83% of the 2016 FPL for a five-person household. At 237.83% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 7.78% of income, or \$438.53 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 (\$453.36 per month) minus your expected contribution (\$438.53 per month), which equals \$14.83 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$15.00 per month in APTC based on the information in the December 5, 2016 application.

The second issue under review is whether you were 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 \$67,640.00 is 237.83% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions based on the information in the December 5, 2016 application.

The third issue under review is whether NYSOH properly determined that you were 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 that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$28,440.00 for a five-person household. Since \$67,640.04 is 237.83% 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.

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

You submitted income documentation that shows in December 2016 your husband received \$6,250.00 in income and that was the only source of your household's income that month.

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 \$3,271.00 per month. Since the documentation you provided shows that your husband earned \$6,250.00 in December 2016, you do not qualify for Medicaid based on your household's monthly income as of the date of your application.

The fourth issue under review is whether NYOSH properly determined that your youngest child was eligible for Child Health Plus with a \$15.00 monthly premium.

According to the record, you expect to file a joint federal income tax return for the 2017 tax year and claim three dependents. Therefore, your child is in a five-person household.

In your December 5, 2016 application, you attested to an expected household income of \$67,640.04. The application also stated that your youngest child is three years old. NYSOH relied upon this information.

A child is eligible to enroll in Child Health Plus if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 223% and 250% of the FPL are responsible for a \$15.00 per month Child Health Plus premium payment.

On the date of your application, the relevant 2016 FPL was \$28,440.00 for a five-person household. Since \$67,640.04 is 237.83% of the 2016 FPL, NYSOH properly found your youngest child to be eligible for Child Health Plus with a \$15.00 monthly premium payment based on your December 5, 2016 application.

The fifth issue under review is whether NYSOH properly determined that your youngest child was ineligible for Medicaid.

Medicaid can be provided through NYSOH to children between the ages of one and nineteen who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 154% of the FPL for the applicable family size. Since \$67,640.04 is 237.83% of the relevant 2016 FPL for a five-person household, NYSOH properly found your youngest child to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

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

You submitted income documentation that shows your household's income in December 2016 was \$6,250.00.

To be eligible for Medicaid, your youngest child would need to meet the non-financial criteria and have a monthly household income no greater than 154% of the FPL, which is \$3,650.00 per month. Since the documentation you provided shows that your husband earned \$6,250.00 in December 2016, your youngest child does not qualify for Medicaid based on your household's monthly income as of the date of your application.

Since the December 6, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$15.00 per month in APTC, you were eligible for cost-sharing reductions, you were ineligible for Medicaid, your youngest child was eligible for Child Health Plus with a \$15.00 monthly premium, and your youngest child was ineligible for Medicaid, it is correct and is AFFIRMED.

This Decision does not affect on any subsequent eligibility determinations made by NYSOH.

Decision

The December 6, 2016 eligibility determination notice is AFFIRMED.

This Decision does not affect on any subsequent eligibility determinations made by NYSOH.

Effective Date of this Decision: May 10, 2017

How this Decision Affects Your Eligibility

This Decision does not affect on your and your youngest child's current eligibility.

NYSOH properly determined you were eligible for up to \$15.00 a month in APTC, effective January 1, 2017.

NYSOH properly determined that you were eligible for cost-sharing reductions, effective January 1, 2017

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NYSOH properly determined you and your youngest child were ineligible for Medicaid, effective January 1, 2017.

NYSOH properly determined that your youngest child was eligible for Child Health Plus with a \$15.00 monthly premium payment, effective January 1, 2017.

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.

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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
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NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The December 6, 2016 eligibility determination notice is **AFFIRMED**.

NYSOH properly determined you were eligible for up to \$15.00 a month in APTC, effective January 1, 2017.

NYSOH properly determined that you were eligible for cost-sharing reductions, effective January 1, 2017.

NYSOH properly determined you and your youngest child were ineligible for Medicaid, effective January 1, 2017.

NYSOH properly determined that your youngest child was eligible for Child Health Plus with a \$15.00 monthly premium payment, effective January 1, 2017.

This Decision does not affect on any subsequent eligibility determinations made by NYSOH.

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&etumi 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.

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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