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

Notice of Decision

Decision Date: June 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016074

[redacted]

Dear [redacted],

On June 1, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 22, 2017 eligibility determination.

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.

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

Decision

Decision Date: June 12, 2017

NY State of Health Account ID
Appeal Identification Number: AP000000016074

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 and your spouse were eligible to receive up to $733.00 per month in advance payments of the premium tax credit (APTC), effective April 1, 2017?

Did NYSOH properly determine you and your spouse were not eligible for cost-sharing reductions (CSR)?

Did NYSOH properly determine that your spouse was not eligible for the Essential Plan?

Did NYSOH properly determine that you and your spouse were not eligible for Medicaid?

Did NYSOH properly determine that your child was eligible for Child Health Plus (CHP) with a monthly premium of $9.00, effective April 1, 2017?

Did NYSOH properly determine that your child was not eligible for Medicaid?

Procedural History

On February 21, 2017, you submitted an application for financial assistance to NYSOH.

On February 22, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to receive up to $733.00 in APTC, and your child was eligible to enroll in CHP with a $9.00 monthly premium, effective April 1, 2017. That notice also stated that you, your spouse, and your child were not eligible for Medicaid, and you and your spouse were not eligible for the Essential Plan, because your income was over the allowable income limits for those programs. You and your spouse were also not eligible CSR because your income was over the limit for that program as well.

Also on February 22, 2017, NYSOH issued a notice of enrollment confirmation confirming your child's enrollment in a CHP plan with a $9.00 monthly premium, beginning April 1, 2017. The notice also confirmed your and your spouse's enrollment in a couple's silver-level qualified health plan (QHP), beginning March 1, 2017, with your APTC applied to your premium as of March 1, 2017 as well.

That same day, you spoke to NYSOH's Account Review Unit and appealed the February 22, 2017 eligibility determination, insofar as you were not found eligible for Medicaid, and your spouse and child were not found eligible for a higher level of financial assistance.

On June 1, 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 through June 16, 2017, to allow you to submit proof of your and your spouse's income for the month of February 2017.

On June 6, 2017, you uploaded a total of nine documents to your NYSOH account. The record is now closed.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim one dependent on that tax return, according to your February 21, 2017 application.

2) You are seeking insurance for yourself, your spouse, and your child.

3) The application that was submitted on February 21, 2017 indicated that you are pregnant and expecting one child, with a due date of [redacted] You confirmed this in your testimony.

4) The application that was submitted on February 21, 2017 listed annual household income of $49,400.00, consisting of $7,800.00 you earn from

your employment, and $41,600.00 your spouse earns from his employment. You testified that this amount was correct.

5) On June 6, 2017, you uploaded the following documentation to your NYSOH account:

   a. A one-page sheet stating that you have submitted all documents (Document [redacted]);
   b. Four paystubs from your employer for the following pay dates and gross pay amounts:
      i. 2/9/17 - $327.85 (Document [redacted]);
      ii. 2/16/17 - $72.92 (Document [redacted]);
      iii. 2/23/17 - $337.70 (Document [redacted]);
      iv. 3/2/17 - $173.65 (Document [redacted]);
   c. Four paystubs from your spouse's employer for the following pay dates and gross pay amounts:
      i. 2/10/17 - $800.00 (Document [redacted]);
      ii. 2/17/17 - $640.00 (Document [redacted]);
      iii. 2/24/17 - $800.00 (Document [redacted]);
      iv. 3/3/17 - $800.00 (Document [redacted]);

   Taken together, these nine documents are marked and entered into the record as "Appellant's Exhibit One."

6) Your application states that you will not be taking any deductions on your 2017 tax return, and you confirmed this in your testimony.

7) Your application states that you live in Ulster County.

8) You testified that you believe that you should be eligible for Medicaid, and you believe your spouse and child might be eligible for additional financial assistance, based on your household income.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

<u>Household Composition</u>

For purposes of APTC, CSR, and the Essential Plan, 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); New

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York's Basic Health Plan Blueprint, pgs. 16-18, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

For purposes of Medicaid and CHP 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; 42 CFR § 457.315(a)).

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a 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 $20,160.00 for a three-person household (81 Federal Register 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution 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 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

CSR is 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)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the FPL or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or CHP as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). 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).

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 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831).

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).

FPL for Pregnant Women

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

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 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)).

In an analysis of CHP 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 2017 FPL, which was $24,600.00 for a four-person household (82 Fed. Reg. 8831).

<u>Medicaid for Children</u>

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 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 2017 FPL, which was $24,600.00.00 for a four-person household (82 Fed. Reg. 8831).

Legal Analysis

<u>Your Eligibility for Financial Assistance</u>

The first issue under review is whether NYSOH properly determined you were eligible for an APTC of up to $733.00 per month, to be shared with your spouse.

The application that was submitted on February 21, 2017 listed an annual household income of $49,400.00, and the eligibility determination relied upon that information.

You are in a three-person household, for purposes of APTC eligibility. You expect to file your 2017 income taxes as married filing jointly and will claim one dependent on that tax return.

You reside in Ulster County, where the second lowest cost silver plan available for a couple through NYSOH costs $1,132.13 per month.

An annual income of $49,400 is 245.04% of the 2016 FPL for a three-person household. At 245.04% of the FPL, the expected contribution to the cost of the health insurance premium is 8.03% of income, or $330.57 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 a couple in your county ($1,132.13 per month) minus your expected contribution ($330.57 per month), which equals $801.56 per month. Therefore, rounding to the nearest dollar, you and your spouse should have been determined eligible to receive up

to $802.00 per month in APTC. NYSOH incorrectly determined you and your spouse to be eligible for up to $733.00 per month in APTC.

The second issue under review is whether you and your spouse were properly found ineligible for CSR. CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of $49,400.00 is 245.04% of the applicable FPL, NYSOH incorrectly found you to be ineligible for CSR. You and your spouse should have been eligible for CSR, based on the information in your application.

The third issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $20,160.00 for a three-person household. Since an annual household income of $49,400.00 is 245.04% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth 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. For pregnant women, the income limit increases to 223% of the FPL, for the applicable family size.

When calculating family size for Medicaid purposes, 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 is expected to deliver.

On the date of your February 21, 2017 application, you indicated that you were pregnant and expecting one child. Therefore, your eligibility for Medicaid should have been determined using a household of four, and an income limit of 223% of the 2017 FPL.

The relevant FPL was $24,600.00 for a four-person household. Since $49,400.00 is 200.81% of the 2017 FPL, you should have been found eligible for Medicaid on an expected annual income basis, using the information provided in your application. NYSOH incorrectly found you ineligible for Medicaid.

Your Spouse's Eligibility for Financial Assistance

The fifth issue under review is whether NYSOH properly determined that your spouse was eligible to receive up to $733.00 per month in APTC, effective April 1, 2017, to be shared with you.

As discussed above, NYSOH erred in its calculations when determining the amount of APTC you and your spouse should have been eligible for, based on your household and income size, and you and your spouse should have been eligible for $802.00 in APTC, utilizing the information in your application.

However, since it has been determined that you should have been eligible for Medicaid, your spouse's eligibility for APTC must be redetermined, as it is now based on the cost of an individual QHP, and not a couple's QHP.

In Ulster County, the second lowest cost silver plan available for an individual through NYSOH costs $566.06 per month.

An annual income of $49,400 is 245.04% of the 2016 FPL for a three-person household. At 245.04% of the FPL, the expected contribution to the cost of the health insurance premium is 8.03% of income, or $330.57 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 ($566.06 per month) minus your spouse's expected contribution ($330.57 per month), which equals $235.49 per month. Therefore, rounding to the nearest dollar, your spouse should have been determined eligible to receive up to $235.00 per month in APTC, assuming you were covered under Medicaid.

The sixth issue under review is whether NYSOH determined that you and your spouse were not eligible for CSR.

As discussed above, your annual income is 245.04% of the applicable FPL for purposes of CSR. Since CSR is available to an individual with an expected annual income that is less than 250% of the application FPL, your spouse should have been found eligible for CSR.

The seventh issue under review is whether NYSOH properly determined that your spouse was not eligible for the Essential Plan.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $20,160.00 for a three-person household. Since an annual household income of $49,400.00 is 245.04% of the

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2016 FPL, NYSOH properly found your spouse to be ineligible for the Essential Plan.

The eighth issue under review is whether NYSOH properly determined that your spouse was not eligible 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.

When calculating family size for Medicaid purposes, 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 is expected to deliver.

On the date of your February 21, 2017 application, you indicated that you were pregnant and expecting one child. Therefore, your spouse's eligibility for Medicaid should have been determined using a household of four.

The relevant FPL was $24,600.00 for a four-person household. Since $49,400.00 is 200.81% of the 2017 FPL, NYSOH correctly found your spouse to be ineligible for Medicaid, based on expected annual income.

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

After the hearing, the record was left open to allow you time to submit documentation of gross pay that you and your spouse received in the month of February 2017. You submitted documentation; however, you did not include a paycheck for February 2, 2017 for yourself, or February 3, 2017 for your spouse. Therefore, the documentation was incomplete.

Nevertheless, even without those two paystubs, your total gross income for February is already at least $2,978.47. To be eligible for Medicaid, your spouse would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,829.00 per month. Since the documentation you provided shows that you and your spouse earned at least $2,978.00 in February 2017, he does not qualify for Medicaid based on monthly income as of the date of your application.

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Your Child's Eligibility for Financial Assistance

The ninth issue under review is whether NYSOH properly determined that your child was eligible for CHP with a monthly premium of $9.00, effective April 1, 2017.

According to the record, you expect to file your 2017 income tax return as married filing jointly, and to claim one dependent. However, for purposes of CHP eligibility, your child is in a household of four because you are pregnant and expecting one child.

In your February 21, 2017 application, you attested to an expected household income of $49,400.00. The application also stated that your child is [redacted] [redacted]. NYSOH relied upon this information.

A child is eligible to enroll in CHP 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 160% and 222% of the FPL are responsible for a $9.00 per month CHP premium payment. On the date of your application, the relevant FPL was $24,600.00 for a four-person household. Since $24,600.00 is 200.81% of the 2017 FPL, NYSOH properly found your child to be eligible for CHP with a $9.00 per month premium payment.

The tenth and final issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid, as of your February 21, 2017 application.

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 that is at or below 154% of the FPL for the applicable family size. Since $49,400.00 is 200.81% of the 2017 FPL for a four-person household, NYSOH properly found your child to be ineligible for Medicaid.

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

As outlined above, you did not submit complete financial documentation to show your income for the month of February 2017.

To be eligible for Medicaid, your child would need to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is $3,157.00 per month. Since the documentation you provided shows that you and your spouse earned at least $2,978.00 in February 2017, unless the two missing paystubs show that you and your spouse earned less than a combined gross

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income of $178.53 in the first week of February, 2017, your child does not qualify for Medicaid based on monthly income, as of the date of your application.

Conclusion

The February 22, 2017 eligibility determination is MODIFIED as follows:

- Your spouse should have been eligible to receive up to $235.00 per month in APTC, and eligible for CSR, effective April 1, 2017;

- You should have been eligible for Medicaid, effective February 1, 2017.

The February 22, 2017 eligibility determination is AFFIRMED, insofar as it stated that your child was eligible to enroll in CHP with a $9.00 monthly premium, effective April 1, 2017.

Decision

The February 22, 2017 eligibility determination notice is MODIFIED as follows:

- Your spouse should have been eligible to receive up to $235.00 per month in APTC, and eligible for CSR, effective April 1, 2017, assuming you were enrolled in Medicaid;

- You should have been eligible for Medicaid, effective February 1, 2017.

The February 22, 2017 eligibility determination is AFFIRMED insofar as it stated that your child was eligible for CHP with a $9.00 monthly premium, effective April 1, 2017.

Your case is RETURNED to NYSOH to effectuate the above changes in eligibility going forward.

About your retroactive eligibility, NYSOH is directed to assist you in retroactively changing your enrollments, in accordance with the above eligibility determination, IF you determine that you would like to retroactively disenroll from your QHP and enroll in Medicaid.

Effective Date of this Decision: June 12, 2017

How this Decision Affects Your Eligibility

Your spouse is eligible to receive up to $235.00 per month in APTC, and eligible for CSR, and should have been found eligible for this financial assistance as of your February 21, 2017 application.

You are eligible for Medicaid, and should have been found eligible for Medicaid as of your February 21, 2017 application.

Your child was correctly found eligible for CHP with a $9.00 monthly premium, effective April 1, 2017.

Your case is being sent back to implement these changes in your eligibility going forward.

PLEASE NOTE: You indicated at the hearing that you wanted your eligibility changed retroactively. Be advised that changing your eligibility retroactively could result in bills that were paid by your QHP being sent back to you for payment, and that there is no guarantee that these bills would be covered by Medicaid. You are advised to immediately contact NYSOH once you have decided whether you want to change your eligibility and enrollments retroactively.

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 February 22, 2017 eligibility determination notice is MODIFIED as follows:

- Your spouse should have been eligible to receive up to $235.00 per month in APTC, and eligible for CSR, effective April 1, 2017, assuming you were enrolled in Medicaid;

- You should have been eligible for Medicaid, effective February 1, 2017.

The February 22, 2017 eligibility determination is AFFIRMED insofar as it stated that your child was eligible for CHP with a $9.00 monthly premium, effective April 1, 2017.

Your case is RETURNED to NYSOH to effectuate the above changes in eligibility going forward.

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With regard to your retroactive eligibility, NYSOH is directed to assist you in retroactively changing your enrollments, in accordance with the above eligibility determination, ONLY IF you determine that you would like to retroactively disenroll from your QHP and enroll in Medicaid.

Your spouse is eligible to receive up to $235.00 per month in APTC, and eligible for CSR, and should have been found eligible for this financial assistance as of your February 21, 2017 application.

You are eligible for Medicaid, and should have been found eligible for Medicaid as of your February 21, 2017 application.

Your child was correctly found eligible for CHP with a $9.00 monthly premium, effective April 1, 2017.

Your case is being sent back to implement these changes in your eligibility going forward.

PLEASE NOTE: You indicated at the hearing that you wanted your eligibility changed retroactively. Be advised that changing your eligibility retroactively could result in bills that were paid by your QHP being sent back to you for payment, and that there is no guarantee that these bills would be covered by Medicaid. You are advised to immediately contact NYSOH once you have decided whether you want to change your eligibility and enrollments retroactively.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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)

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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क 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.

(Urdu)اردو

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.

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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