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

Notice of Decision

Decision Date: August 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017176

[redacted]

Dear [redacted]

On July 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 2, 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.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: August 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017176

[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 you were not eligible for advance payments of the premium tax credit or cost-sharing reductions, effective April 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On March 1, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance.

On March 2, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to purchase a full cost qualified health plan, effective April 1, 2017. This notice stated that you were not eligible for Medicaid, or the Essential Plan because you do not meet the income limits or other eligibility standards, and you do not qualify for an advanced premium tax credit (APTC) because your application states that you are married but would file taxes separately from your spouse.

On March 23, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as you were not eligible for Medicaid through NYSOH.

On July 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was held open until July 31, 2017 to allow you time to submit supporting documentation.

As of the end of the business day on July 31, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was 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) According to your NYSOH account, on your March 1, 2017 application for financial assistance, you indicated that you were married and intended to file your 2017 taxes as single. You will claim no dependents on your tax return. You testified that this information was correct.

2) You testified that you are married, and live with your spouse but you do not file your taxes together.

3) According to your NYSOH account, your income is listed as $18,969.60 consisting of income you earn from your employment. You testified that it was correct.

4) According to your NYSOH account, your spouse's income is listed as $14,123.20 in income she earned from her employment. You testified that you are not sure if this is correct as you do not know how much she made last year, or how much she has earned yet this year.

5) You testified that you feel that your spouse's income should not matter when it comes to what program you are eligible for because it is her income, and not yours.

6) You testified that you had Medicaid through your Local Department of Social Services prior to coming to NYSOH, and you are confused as to why your tax filing status matters.

7) You testified that you are seeking Medicaid through this appeal.

8) You testified that you feel it is unfair that you must file your taxes with your spouse in order to receive financial assistance with health insurance.

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

10) Your application states, and you confirmed, that you live in [redacted].

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

Applicable Law and Regulations

Advance Payments of the Premium Tax Credit

APTC is available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 200% and 400% of the applicable 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)).

Additionally, a tax filer who is married must file a joint return with his or her spouse in order to qualify for APTC (45 CFR §§ 155.305(f), 155.310(d); 26 CFR § 1.36B-2).

However, an individual will be treated as not married at the close of the taxable year if the individual

1) Is legally separated from his/her spouse under a decree of divorce or of separate maintenance, or

2) Meets all of the following criteria:

    a. files a separate return from his/her spouse and maintains his/her household as the primary home for a qualifying child;

    b. pays more than one half of the cost of keeping up his/her home for the tax year; and

    c. does not have his/her spouse as a member of the household during the last 6 months of the tax year

(26 USC § 7703).

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)).

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 applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus 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 $16,020.00 for a two -person household (81 Fed. Reg. 4036).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

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 $16,204.00 for a two -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).

Household Composition

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

In the case of a married couple living together, each spouse is included in the Medicaid household of the other spouse, regardless of whether they expect to file a joint tax return (42 CFR § 435.603 (f)(4)).

In general, household income means the aggregate modified adjusted gross income of every person who is included in the taxpayer's family and is required to file a federal tax return (26 CFR § 1.36B-1(e)).

Legal Analysis

The first issue is whether NYSOH properly determined that you are not eligible for APTC and cost-sharing reductions, effective April 1, 2017.

In the eligibility determination dated March 2, 2017, NYSOH found you ineligible for APTC because you indicated that you were married but did not plan to file a joint federal income tax return.

To qualify for APTC, a person who is married must either file taxes jointly with their spouse, or qualify as “not married” at the close of the tax year.

According to the information in your account and your testimony, you are still married to your spouse, and do not intend on obtaining a decree of divorce or of separate maintenance as of your March 1, 2017 application for financial assistance, or as of your July 12, 2017 hearing. You testified that you do not think it is fair that you must file your taxes jointly with your spouse in order to receive financial assistance with health insurance. However, there is no indication in the record that you meet any of the exceptions that allows a tax filer to be treated as “not married” at the close of a taxable year, making the tax filer eligible for APTC.

Therefore, NYSOH correctly determined in the March 2, 2017 eligibility determination notice that you were not eligible for APTC due to your tax filing status.

Cost-sharing reductions are only available to those who meet the requirements for APTC. Since you do not qualify for APTC, NYSOH correctly found that you were ineligible for cost-sharing reductions.

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

The application that was submitted on March 1, 2017 listed an annual household income of $33,092.80 which consisted of $18,969.60 you earn from your employment, and $14,123.20 your spouse earns from her employment.

You testified that you do not believe that your spouse’s income should be included in your income when calculating your financial assistance because your spouse’s income is hers.

For purposes of determining Medicaid eligibility, there are two people in your household: yourself, and your spouse. Although you and your spouse do not plan to file a joint tax return, your spouse is counted as a household member because you are married and reside together.

Household income consists of the aggregate modified adjusted gross income of every person in the household who is required to file a federal tax return. Here, your household income consists of your own income plus your spouse's income, because both you and your spouse will be filing federal tax returns. Although you and your husband will file separately, NYSOH must include your spouse's income in this analysis.

Therefore, according to the information listed in your March 1, 2017 application, you expected annual household income is $33,092.80 and the eligibility determination relied upon that information.

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 $16,240.00 for a two-person household. Since $33,092.80 is 203.77% of the 2017 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 left the record open until July 31, 2017 to allow you time to submit income documentation for the month of March 2017. However, by the end of the business day on July 31, 2017, there was no income documentation received by the NYSOH's Appeals Unit, nor were there any income documents viewable on your NYSOH account.

Since there is no other reliable income documentation indicating the amount you and your spouse earned in March 2017, a determination as to whether you would qualify for Medicaid on a monthly basis cannot be reached.

Since NYSOH properly determined, based on the information you provided, you were not eligible for APTC because you will not be filing taxes as married filing jointly, are not eligible for cost-sharing reductions because you are not eligible for APTC, and not eligible for Medicaid because you are over the income limit, the March 2, 2017 eligibility determination is AFFIRMED.

Decision

The March 2, 2017 eligibility determination notice is AFFIRMED.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

Effective Date of this Decision: August 9, 2017

How this Decision Affects Your Eligibility

NYSOH properly determined you were ineligible for APTC and cost-sharing reductions.

NYSOH properly determined that you were ineligible for Medicaid.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

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 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).

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 March 2, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined you were ineligible for APTC and cost-sharing reductions.

NYSOH properly determined that you were ineligible for Medicaid.

This Decision has no effect 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:

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.

□□□□□ (Bengali)

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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 निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

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).

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).