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

Notice of Decision

Decision Date: July 28, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000017912

[redacted]

Dear [redacted],

On July 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 11, 2017 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: July 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017912

[redacted]

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 $182.00 per month in advance payments of the premium tax credit (APTC), as of April 11, 2017?
>
> Did NYSOH properly determine that you were ineligible for Medicaid, as of April 11, 2017?

Procedural History

On April 10, 2017, you submitted an application for financial assistance through NYSOH. Based on that application, NYSOH rendered a preliminary eligibility determination that you were eligible for up to $182.00 of APTC.

Also on April 10, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as you were not eligible for Medicaid.

On April 11, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible for a tax credit up to $182.00 per month, effective as of May 1, 2017. Furthermore, the notice stated that you were ineligible for Medicaid because the household income you attested to is over the allowable income limit for that program.

On April 14, 2017, NYSOH issued a notice stating that you were eligible for Medicaid for a limited time, effective as of May 1, 2017. You had been granted Aid to Continue until a decision is made on your appeal.

On July 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until July 26, 2017, to allow you to submit additional documentation to the Appeals Unit.

On July 24, 2017, two-pages of documentation were faxed to the Appeals Unit. That documentation has been made part of the record as "[redacted]." The record is now complete and closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for health insurance for yourself.

2) According to your April 10, 2017 application, you attested to filing your 2017 federal income tax return jointly with your spouse and claiming no dependents on that tax return.

3) According to your April 10, 2017 application, you attested to an annual household income of $40,080.00. Your expected income was $31,200.00, and your spouse's expected income was $8,880.00.

4) You testified you are married, but you do not live with your spouse.

5) You testified that you expect to be filing your 2017 federal income tax return with the tax status of married filing separately and do not expect to claim any dependents on that tax return.

6) According to your account, you reside in [redacted], New York.

7) You testified that you are no longer employed and have not applied for unemployment insurance benefits (UIB).

8) You submitted a letter from your former employer stating that your last day of employment was on June 30, 2017 ([redacted]).

9) You submitted an earnings statement, dated June 29, 2017, for the pay period of June 24, 2017 through June 30, 2017. The statement indicates

that you were issued $600.00 in gross income, with a year-to-date gross income of $15,600.00 ([redacted]).

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

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

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)).

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 $16,020.00 for a two-person household (81 Federal Register 4036).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution in 2017 is between 8.21% and 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

Medicaid - Eligibility

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 $16,240.00 for a two-person household and $12,060.00 for a one-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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for APTC of up to $182.00 per month as of April 11, 2017.

The application that was submitted on April 10, 2017 listed an annual household income of $40,080.00, and the April 11, 2017, eligibility determination relied upon that information.

When calculating family size for APTC, a household size consists of the taxpayer, his or her spouse, and any claimed dependents. You attested in that application that you expected to file your 2017 tax return, jointly with your spouse, and did not expect to claim any dependents on that return. Therefore, you were in a two-person household.

You reside in [redacted], where the second lowest cost silver plan for an individual through NYSOH costs $456.46 per month.

An annual income of $40,080.00 is 250.19% of the 2016 FPL for a two-person household. At 250.19% of the FPL, the expected contribution to the cost of the health insurance premium is 8.22% of income, or $274.55 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 ($456.46 per month) minus your expected contribution ($274.55 per month), which equals $181.91 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $182.00 per month in APTC.

The second issue under review is whether NYSOH properly determined you ineligible for Medicaid as of April 11, 2017.

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.

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 $1,868.00 per month for a two-person household.

The record reflects that your household income is $3,340.00 per month ($40,080.00 / 12 months). Therefore, your monthly household income exceeds the maximum allowable monthly income amount of $1,868.00 and you did not qualify for Medicaid.

Therefore, the April 11, 2017, eligibility determination notice properly determined you eligible for up to $182.00 of APTC and ineligible for Medicaid, and it is AFFIRMED.

During the hearing you testified that you no longer expect to be filing your 2017 federal income tax return jointly with your spouse. You expect to file your tax return with the tax status of married filing separately and do not expect to claim any dependents on that tax return, which for Medicaid purposes would mean you are in a one-person household.

Furthermore, you testified that you are no longer employed and have not applied for unemployment insurance benefits. You submitted a letter from your former employer stating that your last day of employment was on June 30, 2017, and your last earnings statement indicates that you were issued year-to-date gross income of $15,600.00 as of the date of your termination. You also testified that you have not applied for UIB.

Therefore, your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, for an individual living in [redacted], with an expected household income of $15,600.00. NYSOH may require that you provide proof of no income, including that you do not qualify to collect and/or are not collecting UIB.

Decision

The April 11, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, for an individual living in [redacted], with an expected household income of $15,600.00. NYSOH may require that you provide proof of no income, including that you do not qualify to collect and/or are not collecting UIB.

Effective Date of this Decision: July 28, 2017

How this Decision Affects Your Eligibility

You remain eligible for up to $182.00 monthly of APTC and ineligible for Medicaid.

Your case has been sent back to NYSOH to recalculate your eligibility for financial assistance based on the criteria noted above.

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:

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

- By 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 April 11, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, for an individual living in [redacted], with an expected household income of $15,600.00. NYSOH may require that you provide proof of no income, including that you do not qualify to collect and/or are not collecting UIB.

You remain eligible for up to $182.00 monthly of APTC and ineligible for Medicaid.

Your case has been sent back to NYSOH to recalculate your eligibility for financial assistance based on the criteria noted above.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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)

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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 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)

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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