



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

Notice of Decision

Decision Date: September 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017997

[REDACTED]

Dear [REDACTED],

On September 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 29, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: September 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017997



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 \$648.00 per month in advance payments of the premium tax credit, effective May 1, 2017?

Did NYSOH properly determine that you and your spouse were eligible for cost-sharing reductions?

Did NYSOH properly determine that you and your spouse were not eligible for the Essential Plan?

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

Procedural History

On March 28, 2017, you submitted an application for financial assistance.

On March 29, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to receive an advance premium tax credit (APTC) of up to \$648.00 and, if you selected a silver-level plan for enrollment, eligible for cost-sharing reductions (CSR), effective May 1, 2017. That notice also stated that you and your spouse were not eligible for either the Essential Plan or Medicaid because your income was over the allowable income limits for those programs.

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On April 13, 2017, you spoke to NYSOH's Account Review Unit and appeal insofar as you were seeking additional financial assistance with paying for health insurance for you and your spouse. You and your spouse were found eligible for "Aid to Continue" during the pendency of the appeal, so you and your spouse were reenrolled in Medicaid for a limited time.

On September 5, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: A Notice of Award issued by the Social Security Administration (SSA) reflecting your monthly benefits during 2017, and (2) a pension statement issued to you reflecting benefits paid to you during the month of March 2017. The record was to be closed on September 8, 2017 at 5:00 p.m. ET, or upon the receipt of the above referenced documents, whichever occurred earlier.

On September 6, 2017, you provided to the Appeals Unit via facsimile: (1) three earnings statements issued to you by [REDACTED], reflecting pension benefits paid to you on March 1, 2017, and (2) a Notice of Award, dated June 26, 2016, reflecting benefits paid to you by SSA beginning August 2016.

Accordingly, the record was closed on September 6, 2017.

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 no dependents on that tax return.
- 2) You are seeking insurance for you and your spouse.
- 3) The application that was submitted on March 28, 2017 listed annual household income of \$37,020.00, consisting of \$2,300.00 you receive in Social Security benefits and \$785.00 per month you receive in taxable pension benefits from [REDACTED]. You testified that this amount was correct.
- 4) On September 6, 2017, you provided to NYSOH a Notice of Award issued by the SSA reflecting that you received \$2,294.00 in Social Security benefits during the month of March 2017.
- 5) On September 6, 2017, you provided to NYSOH three earnings statements issued to you by [REDACTED], reflecting that

you received a total of \$766.16 in pension benefits during the month of March 2017.

- 6) You live in [REDACTED] New York.
- 7) You testified that you were seeking both you and your spouse to be found eligible for either the Essential Plan or Medicaid, rather than for tax credits to purchase a health plan.

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

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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 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).

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).

Medicaid

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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 (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 is whether NYSOH properly determined that you and your spouse were eligible for an APTC of up to \$648.00 per month, effective May 1, 2017.

The application that was submitted on March 28, 2017 listed an annual household income of \$37,020.00, which consisted of \$2,300.00 you receive in Social Security benefits and \$785.00 per month you receive in taxable pension benefits from [REDACTED]. The eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2017 income taxes as married filing jointly and will claim no dependents on that tax return.

You reside in [REDACTED], where the second lowest cost silver plan available for a couple through NYSOH costs \$880.72 per month.

An annual income of \$37,020.00 is 231.09% of the 2016 FPL for a two-person household. At 231.09% of the FPL, the expected contribution to the cost of the health insurance premium is 7.54% of income, or \$232.51 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 (\$880.72 per month) minus your expected contribution (\$232.51 per month), which equals \$648.21 per month. Therefore, rounding to the nearest

dollar, NYSOH correctly determined you and your spouse to be eligible for an APTC of up to \$648.00 per month.

The second issue is whether you and your spouse were properly found eligible 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 \$37,020.00 is 231.09% of the applicable FPL, NYSOH correctly found you and your spouse to be eligible for CSR.

The third issue under review is whether NYSOH properly determined that you and your spouse 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 \$16,020.00 for a two-person household. Since an annual household income of \$37,020.00 is 231.09% of the 2016 FPL, NYSOH properly found you and your spouse to be not eligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that you and your spouse were 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. On the date of your application, the relevant FPL was \$16,240.00 for a two-person household. Since \$37,020.00 is 227.96% of the 2017 FPL, NYSOH properly found you and your spouse to be not eligible 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.

On September 6, 2017, you provided to NYSOH (1) a Notice of Award issued by the SSA reflecting that you received \$2,294.00 during the month of March 2017, and (2) three earnings statements issued to you by [REDACTED] reflecting that you received a total of \$766.16 during the month of March 2017.

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. Since the documentation you provided shows that you earned \$3,060.16 in

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March 2017 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the March 29, 2017 eligibility determination notice properly stated that, based on the information you provided, you and your spouse were eligible for and APTC of up to \$648.00 per month, eligible for CSR, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The March 29, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to assist you in enrolling a plan for which you and your spouse are eligible.

Effective Date of this Decision: September 13, 2017

How this Decision Affects Your Eligibility

You and your spouse remain eligible for an APTC of up to \$648.00 per month and, if you select a silver-level plan for enrollment, eligible for CSR.

You and your spouse are not eligible for the Essential Plan.

You and your spouse are not eligible for Medicaid, and your limited enrollment in that coverage will end.

Your case is RETURNED to NYSOH to assist you in enrolling a plan for which you and your spouse are eligible.

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.

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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 March 29, 2017 eligibility determination notice is **AFFIRMED**.

You and your spouse remain eligible for an APTC of up to \$648.00 per month and, if you select a silver-level plan for enrollment, eligible for CSR.

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You and your spouse are not eligible for the Essential Plan.

You and your spouse are not eligible for Medicaid, and your limited enrollment in that coverage will end.

Your case is RETURNED to NYSOH to assist you in enrolling a plan for which you and your spouse are eligible.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

বাংলা (Bengali)

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এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

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

Twi (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ 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 איר געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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