



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

Notice of Decision

Decision Date: November 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020523

[REDACTED]

[REDACTED]

On October 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 15, 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: November 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020523



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 and your husband were ineligible to receive advance payments of the premium tax credit, effective August 1, 2017?

Did NY State of Health properly determine that you and your husband were ineligible for cost-sharing reductions?

Did NY State of Health properly determine that you and your husband were ineligible for the Essential Plan?

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

Did NY State of Health properly determine your three children were ineligible for Medicaid?

Did NY State of Health properly determine your three children were eligible for a full cost Child Health Plus plan?

Procedural History

On July 11, 2017, you submitted an application for financial assistance for your household.

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On July 12, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you and your husband were eligible to purchase a qualified health plan at full cost, effective August 1, 2017. The notice further stated that your three children were eligible to purchase a qualified health plan at full cost, effective August 1, 2017. That notice also stated that you and your husband were not eligible for advance premium tax credits, cost sharing reductions, the Essential Plan, or Medicaid, because your income was over the allowable income limits for those programs. Your children were not eligible for Child Health Plus because your income was over the allowable income limit for that program.

On July 14, 2017, NYSOH received your application for financial assistance, that day a preliminary eligibility determination was prepared stating you and your husband were eligible to purchase a qualified health plan at full cost, effective August 1, 2017. The determination also stated your three children were eligible to purchase a qualified health plan at full cost, effective August 1, 2017.

On July 14, 2017, you spoke to NYSOH's Account Review Unit and appealed the level of financial assistance you were determined eligible to receive.

On July 15, 2017, NYSOH issued a notice of eligibility determination stating that you and your husband were eligible to purchase a qualified health plan at full cost, effective August 1, 2017. The notice further stated your three children were eligible to purchase a qualified health plan at full cost, effective August 1, 2017. That notice also stated that you were not eligible for advance premium tax credits, cost sharing reductions, the Essential Plan, or Medicaid, because your income was over the allowable income limits for those programs. Your children were not eligible for Child Health Plus because your income was over the allowable income limit for that program.

On October 3, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the proceeding.

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 three dependents on that tax return.
- 2) You are seeking insurance for yourself, your husband, and your three children.

- 3) The application that was submitted on July 14, 2017, listed annual household income for 2017 of \$130,978.24, consisting of income your husband earns from his employment.
- 4) The application stated your husband has three sources of income.
- 5) The application submitted shows your husband receives income through [REDACTED] of \$25,000.00 yearly, and [REDACTED] of \$50,000.00 yearly. It also has income of \$24,636.79 from January 1, 2017 to February 28, 2017. You testified these amounts were correct.
- 6) The application on July 14, 2017 states your husband received a severance amount of \$31,341.45. You testified this was correct and received this in March 2017 in addition to the income from that location for the first two months of 2017.
- 7) You testified that your monthly income for July was \$5,769.00 which you entered in your application.
- 8) Your application states that you are not sure if you will be taking any deductions on your 2017 tax return.
- 9) Your children at the time of your application were ages [REDACTED] and [REDACTED].
- 10) Your application states 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 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:

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- 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).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is \$28,440.00 for a five-person household (81 Federal Register 4036).

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 \$28,440.00 for a five-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

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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

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 \$28,780.00 for a five-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).

Medicaid for Children

A child who is under one year of age 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 223% 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).

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all

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persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

On the date of your application, that was the 2017 FPL, which is \$28,780.00 for a five-person household (82 Fed. Reg. 8831).

Child Health Plus

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

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

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

In an analysis of Child Health Plus eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4).

On the date of your application, that was the 2017 FPL, which is \$28,780.00 for a five-person household (82 Fed. Reg. 8831).

Legal Analysis

The first issue is whether NYSOH properly determined that you and your husband were ineligible to receive advance payments of the premium tax credit, effective August 1, 2017.

The application that was submitted on July 14, 2017 listed an annual household income of \$130,978.24 and the eligibility determination relied upon that information.

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You and your husband are in a five-person household. You expect to file your 2017 income taxes as married filing jointly and will claim three dependents on that tax return.

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan and expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL).

An annual income of \$130,978.24 is 460.54% of the 2016 FPL for a five-person household. At 460.54% of the FPL, you and your husband would be ineligible for APTC.

Since your household income exceeds the income limit for APTC, NYSOH correctly determined you and your husband were eligible for a full cost qualified health plan and ineligible for APTC, effective August 1, 2017.

The second issue is whether you and your husband were properly found ineligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of \$130,978.24 is 460.54% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you and your husband were ineligible 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 (MAGI) that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$28,440.00 for a five-person household. Since an annual household income of \$130,978.24 is 460.54% of the 2016 FPL, NYSOH properly found you and your husband to be ineligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that you and your husband were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$28,780.00 for a five-person household. Since \$130,978.24 is 455.10% of the 2017 FPL, NYSOH properly found you and your husband to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

The fifth issue is whether NYSOH properly determined that your three children were ineligible for Medicaid.

At the time of your application your children's ages were [REDACTED] and [REDACTED] years old. Your children reside in a five-person household.

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 MAGI that is at or below 154% of the FPL for the applicable family size. Since \$130,978.24 is 455.10% of the 2017 FPL for a five-person household, NYSOH properly found your two oldest children ineligible for Medicaid.

Medicaid can be provided through NYSOHH to children under one year of age if he or she meets the non-financial criteria and has a household MAGI that falls at or below 223% of the FPL for the applicable family size. Since \$130,978.24 is 455.10% of the 2017 FPL for a five-person household, NYSOH properly found your youngest child ineligible for Medicaid.

The sixth issue is whether NYSOH properly determined that your three children were eligible for a full cost Child Health Plus plan.

A child is eligible to enroll in Child Health Plus with financial assistance if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. On the date of your application, the relevant FPL was \$28,780.00 for a five-person household. Since \$130,978.24 is 455.10% of the 2017 FPL, NYSOH properly found your children to be ineligible for financial assistance with their Child Health Plus eligibility.

Since the July 15, 2017 eligibility determination notice properly stated that, based on the information you provided, you and your husband were eligible to purchase a qualified health plan at full cost, ineligible for APTC, cost sharing reductions, the Essential Plan, or Medicaid, and your three children eligible for Child Health Plus at full cost, and ineligible for Medicaid it is correct and must be AFFIRMED.

Decision

The July 15, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 13, 2017

How this Decision Affects Your Eligibility

You and your husband remain eligible for a full cost qualified health plan.

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).

You and your husband are ineligible for cost-sharing reductions.

You and your husband are ineligible for the Essential Plan.

You and your husband are ineligible for Medicaid.

Your three children are ineligible for Medicaid.

Your three children are eligible for a full cost Child Health Plus plan.

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):

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

Summary

The July 15, 2017 eligibility determination notice is AFFIRMED.

You and your husband remain eligible for a full cost qualified health plan.

You and your husband are ineligible for cost-sharing reductions.

You and your husband are ineligible for the Essential Plan.

You and your husband are ineligible for Medicaid.

Your three children are ineligible for Medicaid.

Your three children are eligible for a full cost Child Health Plus plan.

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.

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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।

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.

Twí (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

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

אידיש (Yiddish)

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