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: AP000000021609

[redacted]

[redacted]

On October 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 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: November 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021609

[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 your older daughter, [redacted], was eligible to receive $0.00 per month in advance payments of the premium tax credit for a limited time, effective September 1, 2017?
>
> Did NYSOH properly determine that your older daughter was eligible for cost-sharing reductions for a limited time?
>
> Did NYSOH properly determine that your older daughter was not eligible for the Essential Plan?
>
> Did NYSOH properly determine that your older daughter was not eligible for Medicaid?

Procedural History

On July 20, 2017, NYSOH received (1) a Social Security Benefit Statement (Form SSA-1099), reflecting that your younger child, [redacted] received a total of $16,176.00 in [redacted] during 2016, (2) two earnings statements issued to you by your employer, [redacted] on June 29, 2017 and July 13, 2017, and (3) a Form 1099-R reflecting that you received $2,161.32 in [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).

On August 10, 2017, you submitted an updated application for financial assistance.

On August 11, 2017, NYSOH issued a notice of eligibility determination stating that your older daughter was eligible to receive an advance premium tax credit (APTC) of $0.00 for limited time and, if selected a silver-level plan for enrollment, eligible for cost-sharing reductions (CSR) for a limited time, effective September 1, 2017. That notice also stated that your older daughter was not eligible for the Essential Plan or Medicaid because her household income was over the allowable income limits for those programs.

On August 18, 2017, you submitted a letter to NYSOH's Account Review Unit requesting an appeal of your older daughter's eligibility insofar as you were seeking additional financial assistance for her enrollment in an affordable health insurance plan.

Also on August 18, 2017, NYSOH received (1) a General Information System message ( ) clarifying the treatment of a dependent's income when computing the consumer's Modified Adjusted Gross Income (MAGI), (2) a letter issued by dated August 11, 2017, reflecting that hourly rate of compensation and typical work schedule, and a bill reflecting your outstanding balance for your older daughter's tuition at .

On October 2, 2017, NYSOH received two additional earnings statements issued to you by , Inc on August 24, 2017 and September 7, 2017.

On October 30, 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: (1) a monthly statement of issued by reflecting your annuity payment, and (2) a Administration (SSA) notice of award issued to your youngest reflecting her for either 2017 or 2018, or reasonably acceptable evidence reflecting the same. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier.

On November 2, 2017, you provided to NYSOH Appeals Unit through your NYSOH account (1) your application summary of Insurance Benefits for your claim, originally submitted to on December 11, 2007, and (2) a monthly statement issued by reflecting an annuity payment made to you for the period between September 30, 2017 and October 27, 2017. Accordingly, the record was closed on November 2, 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 head of household. You will claim both of your daughters as dependents on that tax return.

2) You are seeking insurance for your older [redacted], since your younger [redacted] is already enrolled in a Child Health Plus (CHP) plan through NYSOH.

3) The application that was submitted on August 10, 2017, listed an annual household income of $40,806.00, consisting of $42,770.00 you anticipate earning from your employment with [redacted] during 2017, $503.00 per month in taxable annuity benefits you receive from [redacted], and approximately $8,000.00 in deductions you will claim on your 2017 tax return from the tuition and fees you will incur from your [redacted] schooling. You testified that these amounts were correct.

4) You testified, and your application reflects, that your younger [redacted] receives $1,358.00 per month in [redacted]. You further testified that you believed the eligibility result of your older [redacted] was partially due to these [redacted] being included within the household income.

5) You live in [redacted].

6) You testified that you were seeking additional financial assistance for your older [redacted] since purchasing a health plan for your daughter at full cost would be unaffordable to you.

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 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).

<u>Cost-Sharing Reductions</u>

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 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 $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 $20,420.00 for a three-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).

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)).

Legal Analysis

The first issue is whether NYSOH properly determined that your older daughter was eligible for an APTC of $0.00 per month for a limited time, effective September 1, 2017.

The application that was submitted on August 10, 2017 listed an annual household income of $40,806.00, which consisted of $42,770.00 you anticipated earning from your employment with [redacted] during 2017, $6,036.00 ($503.00 x 12 months) in taxable annuity benefits you anticipate receiving from [redacted], and approximately $8,000.00 in deductions you will claim on your 2017 tax return from the tuition and fees you will incur from your older daughter's schooling. The eligibility determination relied upon that information.

You testified that you did not believe that your younger [redacted] should not be counted toward your annual household income in assessing your [redacted] eligibility. The record reflects that your [redacted] were not included in your household's annual household income when determining your [redacted] eligibility.

Your [redacted] is in a three-person household. You expect to file your 2017 income taxes as head of household and will claim your [redacted] as dependents on that tax return.

You reside in [redacted] where the second lowest cost silver plan available for a dependent child only through NYSOH costs $204.74 per month.

An annual income of $40,806.00 is 202.41% of the 2016 FPL for a three-person household. At 202.41% of the FPL, the expected contribution to the cost of the health insurance premium is 6.52% of income, or $221.57 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 dependent child only in your county ($204.74 per month) minus your expected contribution ($221.57 per month). Therefore, because your expected contribution exceeds the cost of the second lowest cost silver plan available through NYSOH for a dependent child in your county, NYSOH correctly determined your older daughter to be eligible $0.00 per month in APTC.

The second issue is whether your older daughter was properly found eligible for CSR for a limited time.

CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of $40,806.00 is 202.41% of the applicable FPL, NYSOH correctly found you to be eligible for CSR for a limited time.

The third issue under review is whether NYSOH properly determined that your older daughter 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 $40,806.00 is 202.41% of the 2016 FPL, NYSOH properly found your older daughter to be not eligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that your older daughter 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. However, since your older daughter is 19 years old and is residing with you, she would be eligible for Medicaid provided she was at or below 155% of applicable FPL. On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Since $40,806.00 is 202.41% of the 2017 FPL, NYSOH properly found your older daughter 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.

The credible evidence of record reflects that you received during the month of your application, August 2017, $503.00 from the [redacted] However, there is insufficient documentation in your account to confirm the total gross income you received from your position at [redacted], Inc. during August 2017. Furthermore, while you have provided documentation confirming that you have a $8,513.00 balance due from [redacted] your older [redacted], it is not evident whether these amounts were actually paid. They can therefore not be used to determine the appropriate deduction from your

household income. Accordingly, we have insufficient information to confirm your total income during the month of August 2017.

For your older daughter to be eligible for Medicaid, she would need to meet the non-financial criteria and have an income no greater than 155% of the FPL, which is $2,638.00 per month. Since the documentation you provided is incomplete, we are unable return your case to NYSOH for a redetermination of your [redacted].

Since the August 11, 2017 eligibility determination notice properly stated that, based on the information you provided, your older daughter was eligible for $0.00 in APTC for a limited time, eligible for CSR for a limited time, not eligible for the Essential Plan not eligible for Medicaid, it is correct and is AFFIRMED.

Decision

The August 11, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 13, 2017

How this Decision Affects Your Eligibility

Your [redacted] remains eligible to enroll in a qualified health plan at full cost.

Your [redacted] remains effectively not eligible for APTC at this time.

Your [redacted] is eligible for CSR for a limited time.

Your [redacted] is not eligible for either the Essential Plan or Medicaid.

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.

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).

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 August 11, 2017 eligibility determination notice is AFFIRMED.

Your older daughter remains eligible to enroll in a qualified health plan at full cost.

Your older daughter remains effectively not eligible for APTC at this time.

Your older daughter is eligible for CSR for a limited time.

Your older daughter is not eligible for either the Essential Plan or Medicaid.

Legal Authority

We are sending you this notice in accordance with 45 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).

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)

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।

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).

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.

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.

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).