



STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: December 15, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022258

[REDACTED]

[REDACTED]

On December 1, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 9, 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
PO 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(b).

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
PO Box 11729
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Decision

Decision Date: December 15, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022258

[REDACTED]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health (NYSOH) properly determine that you and your spouse were eligible for the Essential Plan and not eligible for advance payments of the premium tax credit, cost sharing reductions, or Medicaid, effective October 1, 2017?

Procedural History

On September 7, 2017, you uploaded a copy of your 2016 federal tax return to your NYSOH account.

On September 8, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to receive up to \$722.00 per month in advance payments of the premium tax credit (APTC), as well as cost sharing reductions, effective October 1, 2017. The notice also stated that you and your spouse were not eligible for the Essential Plan or Medicaid because your household income was over the allowable income limits for those programs.

Also on September 8, 2017, you updated your application to NYSOH for financial assistance with your health insurance. That day, a preliminary eligibility determination was prepared, stating that you and your spouse were conditionally eligible for the Essential Plan, effective October 1, 2017.

Also on September 8, 2017, you spoke to NYSOH's Account Review Unit and appealed your financial eligibility insofar as you are seeking to be determined eligible for Medicaid.

On September 14, 2017, NYSOH issued a notice of eligibility determination, based on your September 8, 2017 application, stating that you and your spouse were conditionally eligible for the Essential Plan with a \$20.00 monthly premium, effective October 1, 2017. The notice also stated that you and your spouse were not eligible for Medicaid because your household income was over the allowable income limits for that program. The notice also directed you to provide proof of income by December 7, 2017.

On December 1, 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 hearing.

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 yourself and your spouse.
- 3) On September 7, 2017, you uploaded a copy of your 2016 federal tax return to your NYSOH account.
- 4) On September 8, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for APTC in the amount of \$722.00 per month, as well as cost sharing reductions, effective October 1, 2017. The notice also stated that you and your spouse were not eligible for the Essential Plan or Medicaid because your household income was over the allowable income limits for those programs.
- 5) NYSOH records show that the September 8, 2017 eligibility determination (referenced above) was based on the income reflected in your 2016 federal tax return consisting of \$14,356.00 in dividends, \$22,363.00 in capital gains, and \$512.00 in taxable interest. Your household income was determined to be \$33,731.00 after subtracting \$3,500.00 in deductions.
- 6) You subsequently submitted an updated application to NYSOH on September 8, 2017, which listed an annual household income of \$24,315.00, consisting of \$8,000.00 in dividends, \$20,003.00 in capital gains and \$512.00 in taxable interest. NYSOH records reflect that your

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household income was determined to be \$24,315.00 after subtracting \$4,200.00 in deductions for 2017.

- 7) You testified during the December 1, 2017 hearing that in 2017 you expect to have approximately the same household income as in 2016.
- 8) Your application states that you live in [REDACTED].
- 9) You testified that you are appealing the determination finding you and your spouse eligible for the Essential Plan insofar as you are seeking to be determined eligible for Medicaid.

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), 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).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

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 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 Federal Register 4036).

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, see www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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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 \$16,240.00 for a two-person household (82 Federal Register 8831, 8832).

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 issue under review is whether NYSOH properly determined that you and your spouse were eligible for the Essential Plan and not eligible for APTC, cost sharing reductions, or Medicaid, effective October 1, 2017.

On September 7, 2017, you uploaded your 2016 federal tax return to your NYSOH account.

On September 8, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for an advance premium tax credit in the amount of \$722.00 per month as well as cost sharing reductions, effective October 1, 2017. The notice also stated that you and your spouse were not eligible for the Essential Plan or Medicaid because your household income was over the allowable income limits for those programs.

NYSOH records reflect that the September 8, 2017 eligibility determination (as noted above) was based on the income listed in your 2016 federal tax return consisting of \$14,356.00 in dividends, \$22,363.00 in capital gains and \$512.00 in

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taxable interest. Your household income was determined to be \$33,731.00 after subtracting \$3,500.00 in deductions.

You subsequently submitted an updated application to NYSOH on September 8, 2017, which listed an annual household income of \$24,315.00, consisting of \$8,000.00 in dividends, \$20,003.00 in capital gains and \$512.00 in taxable interest. NYSOH records reflect that your household income was determined to be \$24,315.00 after subtracting \$4,200.00 in deductions for 2017.

You testified during the December 1, 2017 hearing that in 2017 you expect to have approximately the same household income as in 2016. However, this testimony is inconsistent given the income attested to in your September 8, 2017 application (\$24,315.00), when compared to your household income from 2016 (\$33,731.00).

Therefore, based on your testimony that in 2017 you expect to have approximately the same household income as in 2016, your case is being RETURNED to NYSOH to redetermine you and your spouse's eligibility based on a two-person household residing in [REDACTED] with a household income of \$33,731.00.

Decision

The September 9, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine you and your spouse's eligibility based on a two-person household residing in [REDACTED] with a household income of \$33,731.00.

Effective Date of this Decision: December 15, 2017

How this Decision Affects Your Eligibility

Your case is being RETURNED to NYSOH to redetermine you and your spouse's eligibility based on a two-person household residing in New York County with a household income of \$33,731.00.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the

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dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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:

- By calling the Customer Service Center at 1-855-355-5777

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- By mail at:
NY State of Health Appeals
PO Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The September 9, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine you and your spouse's eligibility based on a two-person household residing in New York County with a household income of \$33,731.00.

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 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।

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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 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&btumi 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.