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

Notice of Decision

Decision Date: January 5, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022983

[redacted]

On December 1, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 3, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: January 5, 2018

NY State of Health Account ID: [redacted]
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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 not eligible for advance payments of the premium tax credit, cost sharing reductions, or the Essential Plan, effective November 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On October 2, 2017, you applied to NYSOH for financial assistance with your health insurance. That day, a preliminary eligibility determination was prepared, finding in part, that you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017.

Also on October 2, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not eligible for financial assistance or Medicaid.

On October 3, 2017, NYSOH issued an eligibility determination notice, based on the October 2, 2017 application, stating in part, that you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017. That notice also stated that you were not eligible for Medicaid, or the Essential Plan because you did not meet the income limits or other eligibility standards, and you did not qualify for an advanced premium tax credit (APTC) or cost-sharing reductions because your household income of $72,945.19 was over the allowable income limits for those programs.

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 held open until December 18, 2017, to allow you to submit supporting documents. On December 3, 2017, you submitted via secure facsimile to the NYSOH Appeals Unit fourteen-pages of documents including your NYS Unemployment Benefits Statement and nine weekly earnings statements for your spouse [redacted] for pay dates of 10/6/2017 through 12/1/2017. (*see* [redacted]. Those documents have been collectively marked as Appellant's Exhibit # 1 and are included in the record. The record was closed at that time.

Findings of Fact

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

1) You are seeking to be found eligible for Medicaid or some other financial assistance program.

2) 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.

3) You are seeking insurance for yourself only.

4) The application that was submitted on October 2, 2017, listed annual household income of $72,945.19, consisting of $38,145.19 you earn from your employment and $ 34,800.00 your spouse receives from his employment. You testified that this total amount was correct at the time.

5) You testified that your employment ended on September 27, 2017.

6) You testified that you started receiving unemployment insurance benefits in the amount of $435.00 a week with the first benefit payment received October 27, 2017.

7) According to the NYS Department of Labor record of benefit payments, you received $435.00 on 10/27/2017, 10/31/2017, 11/07/2017, 11/14/2017 11/21/2017, and 11/28/2017.

8) According to your testimony and the earnings statements that you submitted, your spouse is employed at [redacted] and earns $1,125.00 in gross pay each week.

9) The documentation you provided show your spouse received $1,635.00 in gross pay on 10/06/2017, and $1,125.00 in gross pay on 10/13/2017, 10/20/2017and 10/27/2017.

10) According to the documentation you provided, your monthly household income for October 2017 was $5,880.00.

11) Your application states that you will not be taking any deductions on your 2017 tax return.

12) Your application states that you live in Queens County, New York.

13) You testified that you think you should be eligible for Medicaid because you received that health insurance in the past when you lost employment.

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 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 NYSOH 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 Revenue Procedure (RP) 2016-24).

In an analysis of APTC eligibility, the determination is based on the applicable 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 greater than 400% of the 2016 FPL, the expected contribution is between 9.69% of the household income (26 CFR § 1.36B-3, IRS RP 2016-24).

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 federal income tax return). Those who take less tax credit in advance than they can 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 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 Federal Register 4036).

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 first issue is whether NYSOH properly determined that you were not eligible for APTC, cost sharing reductions, or the Essential Plan, effective November 1, 2017.

The application that was submitted on October 2, 2017 listed an annual household income of $72,945.19 and the eligibility determination relied upon that information. During the hearing, you testified that this amount was a good estimate at the time.

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.

APTC can be approved for individuals whose annual income does not exceed 400% of the applicable FPL. An annual income of $72,945.19 is 455.33% of the 2016 FPL for a two-person household.

Therefore, NYSOH correctly determined in the October 3, 2017 eligibility determination notice that you were not eligible for APTC because you were over the allowable income level for that program.

Cost-sharing reductions are only available to those who meet the requirements for APTC. Since you do not qualify for APTC, NYSOH correctly found that you were ineligible for cost-sharing reductions.

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 $72,945.19 is 455.33% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The second issue is whether NYSOH properly determined that you 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 October 2, 2017 application, the relevant FPL was $16,240.00 for a two-person household. Since $72,945.19 is 449.17% of the 2017 FPL, NYSOH properly found you to be ineligible 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.

During the hearing, you testified that you lost your employment on September 27, 2017. You testified that you applied for unemployment insurance benefits and that after the waiting period you received your first benefit payment of $435.00 on October 27, 2017. You submitted a copy of your NYS Department of Labor record of unemployment insurance benefit payments, that shows you received $435.00 on October 27, 2017 and $435.00 on October 31, 2017. You also submitted earnings statements from [redacted] where your spouse is employed. Those statements reflect that he received $1,635.00 in gross pay on October 6, 2017 and $1,125.00 in gross pay on October 13, 2017, October 20, 2017 and October 27, 2017. Therefore, according to documentation in the record, your monthly household income for October 2017 was $5,880.00.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the 2017 FPL, which is $1,868.00 per month. Since the documentation you provided shows that your household income was $5,880.00 for October 2017, which exceeds the monthly allowable income of $1,387.00 to be eligible for Medicaid.

Therefore, you do not qualify for Medicaid based on monthly income as of the date of your October 2, 2017 application for financial assistance.

Since NYSOH properly determined that, based on the information you provided, you were not eligible for APTC, not eligible for cost-sharing reductions because you are not eligible for APTC, and not eligible for either the Essential Plan or Medicaid because you are over the income limits for those programs, the October 3, 2017 eligibility determination notice is correct and is AFFIRMED.

Decision

The October 3, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 5, 2018

How this Decision Affects Your Eligibility

NYSOH properly determined you were ineligible for APTC and cost-sharing reductions.

NYSOH properly determined that you were ineligible for the Essential Plan and Medicaid.

The October 3, 2017 eligibility determination notice properly determined that you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017.

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 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
- By mail at:

  NY State of Health Appeals
  PO Box 11729

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 2, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined you were ineligible for APTC and cost-sharing reductions.

NYSOH properly determined that you were ineligible for the Essential Plan and Medicaid.

The October 3, 2017 eligibility determination notice properly determined that you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017.

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)

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 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.

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).