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

Notice of Decision

Decision Date: December 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023138

[redacted]

[redacted]

On December 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 30, 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
  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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Decision

Decision Date: December 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023138

[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 you and your spouse were eligible to receive up to $523.00 per month in advance payments of the premium tax credit, effective November 1, 2017?
>
> Did NYSOH properly determine that you and your spouse were eligible for cost-sharing reductions (CSR)?
>
> 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 September 29, 2017, you applied to NYSOH for financial assistance with your health insurance.

Also on September 29, 2017, NYSOH received (1) a letter issued by [redacted] dated August 1, 2017, confirming acceptance of your resignation effective August 4, 2017, (2) four earnings statements issued to your spouse between September 1, 2017 and September 29, 2017, (3) a undated letter issued by [redacted] confirming that your spouse's employment with [redacted] ended on March 10, 2017, and (4) and an [redacted]

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screenshot reflecting that your spouse was no longer employed by that organization.

On September 30, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to receive an advance premium tax credit (APTC) of up to $523.00 per month and, if you enrolled in a silver-level qualified health plan (QHP), eligible to receive cost-sharing reductions (CSR), effective November 1, 2017. That notice also stated that you and your spouse were not eligible for either the Essential Plan or Medicaid because your household income was over the allowable income limits for those programs.

On October 5, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you and your spouse were not found eligible for additional financial assistance, including the Essential Plan and Medicaid.

On December 4, 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 one dependent on that tax return.

2) You are seeking insurance for yourself and your spouse.

3) The application that was submitted on September 29, 2017, listed annual household income of $44,891.20, consisting of $4,972.80 and $4,558.40 you received from your employer, [redacted], between January 1, 2017 and March 31, 2017, and between May 30, 2017 and August 4, 2017, respectively, and $17.00 per hour your spouse anticipates receiving from [redacted] over a typical 40-hour work week during 2017. You testified that this total amount was reasonably accurate.

4) On September 29, 2017, you provided to NYSOH four earnings statements issued to your spouse by his employer, reflecting that he received (1) $680.00 on September 1, 2017, (2) $680.00 on September 8, 2017, (3) $680.00 on September 15, 2017, (4) $782.00 on September 22, 2017, and (5) $692.75 on September 29, 2017.

5) You testified, and your application reflects, that you will not be taking any deductions on your 2017 tax return.

6) You live in [redacted].

7) You testified that the plans available to you and your spouse, even after applying the maximum APTC available, are unaffordable. You further testified that you were seeking to be found eligible for either the Essential Plan or 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 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 $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-3, IRS RP 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 $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, 8832).

Legal Analysis

The first issue is whether NYSOH properly determined that you and your spouse were eligible to receive up to $523.00 per month in APTC, effective November 1, 2017.

The application that was submitted on September 29, 2017 listed an annual household income of $44,891.20, consisting of $4,972.80 and $4,558.40 you received from your employer, [redacted]., between January 1, 2017 and March 31, 2017, and between May 30, 2017 and August 4, 2017, respectively, $35,360.00 ($17.00 per hour x 40 hours x 52 weeks) your spouse anticipates receiving from [redacted] during 2017. The eligibility determination relied upon that information.

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

You reside in Erie County, where the second lowest cost silver plan available for a couple through NYSOH costs $793.96 per month.

An annual income of $44,891.20 is 222.67% of the 2016 FPL for a three-person household. At 222.67% of the FPL, the expected contribution to the cost of the health insurance premium is 7.24% of income, or $270.74 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 ($793.96 per month) minus your expected contribution ($270.74 per month), which equals $523.22 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to $523.00 per month in APTC.

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 applicable FPL. Since a household income of $44,891.20 is 222.67% 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 $20,160.00 for a three-person household. Since an annual household income of $44,891.20 is 222.67% 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 $20,420.00 for a three-person household. Since $44,891.20 is 219.84% 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.

The record reflects that on September 29, 2017, you provided to NYSOH four earnings statements issued to your spouse by his employer, reflecting that he received (1) $680.00 on September 1, 2017, (2) $680.00 on September 8, 2017, (3) $680.00 on September 15, 2017, (4) $782.00 on September 22, 2017, and (5) $692.75 on September 29, 2017. Accordingly, your household income during the month of your application, September 2017, was $3,514.75.

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 $2,349.00 per month. Since the documentation you provided shows that you earned $3,514.75 in September 2017, you and your spouse do not qualify for Medicaid based on monthly income as of the date of your application.

Because the September 30, 2017 eligibility determination notice properly stated that, based on the information you provided, you and your spouse were eligible for up to $523.00 per month in APTC, eligible for CSR, not eligible for the Essential Plan, and not eligible for Medicaid, it is correct and is AFFIRMED.

Decision

The September 30, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: December 12, 2017

How this Decision Affects Your Eligibility

You and your spouse were eligible for an APTC of up to $523.00 per month and, if you had enrolled in a silver-level plan, eligible for CSR, effective November 1, 2017.

You and your spouse were not eligible for either the Essential Plan or Medicaid.

This decision relates to the eligibility of you and your spouse for financial assistance for 2017 ONLY. You must update your NYSOH application to find out you and your spouse's eligibility for financial assistance for 2018. Your application and enrollment in a plan must be completed by December 15, 2017 for any changes to be in effect for January 1, 2018. Open enrollment for 2018 coverage ends on January 31, 2018.

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 September 30, 2017 eligibility determination notice is AFFIRMED.

You and your spouse were eligible for an APTC of up to $523.00 per month and, if you had enrolled in a silver-level plan, eligible for CSR, effective November 1, 2017.

You and your spouse were not eligible for either the Essential Plan or Medicaid.

This decision relates to the eligibility of you and your spouse for financial assistance for 2017 ONLY. You must update your NYSOH application to find out you and your spouse's eligibility for financial assistance for 2018. Your

application and enrollment in a plan must be completed by December 15, 2017 for any changes to be in effect for January 1, 2018. Open enrollment for 2018 coverage ends on January 31, 2018.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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।

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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 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.

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