



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

## Notice of Decision

Decision Date: January 05, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000023422

[REDACTED]

[REDACTED]

On December 18, 2017, you and your Authorized Representative appeared by telephone at a hearing on your appeal of NY State of Health's October 18, 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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STATE OF NEW YORK  
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## Decision

Decision Date: January 05, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000023422



## 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 eligible to receive up to \$67.00 per month in advance payments of the premium tax credit, effective December 1, 2017?

Did NYSOH properly determine that you were not eligible for cost-sharing reductions?

Did NYSOH properly determine that you were not eligible for the Essential Plan?

Did NYSOH properly determine that you were not eligible for Medicaid?

## Procedural History

On October 17, 2017, you applied to NYSOH for financial assistance with your health insurance. That day, a preliminary eligibility determination was prepared, stating that you were eligible to receive an advance premium tax credit (APTC) up to \$67.00 per month, effective December 1, 2017.

Also on October 17, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were seeking eligibility for Medicaid.

On October 18, 2017, NYSOH issued a notice of eligibility determination, based on the October 17, 2017 application, stating that you were eligible to receive an APTC of up to \$67.00 per month, effective December 1, 2017. That notice also

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stated that you were not eligible for cost-sharing reductions (CSR), the Essential Plan and Medicaid because your household income was over the allowable income limits for those programs.

On December 18, 2017, you and your Authorized Representative, [REDACTED], 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) all earnings statements issued to by each of your employers, [REDACTED] during the months of October and November 2017, and (2) all earnings statement issued to your spouse by his employer, [REDACTED], during the months of October and November 2017. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier. No additional documents were received from you by January 2, 2017.

Accordingly, the record was closed on January 2, 2017.

## Findings of Fact

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

- 1) You testified that you wanted your certified application counselor, [REDACTED] to act as your Authorized Representative during the hearing.
- 2) Your Authorized Representative stated, and your NYSOH account reflects, 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. However, your Authorized Representative further stated, and your NYSOH account reflects, that you were pregnant with one child with an anticipated due date of [REDACTED].
- 3) You are seeking insurance for yourself only.
- 4) The application that was submitted on October 17, 2017, listed annual household income of \$53,216.54, consisting of \$22,276.80 you earned from your employment with [REDACTED] January 1, 2017 and October 15, 2017, \$125.00 you earn from your employment with [REDACTED] once every two weeks, and \$1,064.99 your spouse earns once every two weeks from [REDACTED]. Your Authorized Representative stated that this total amount was correct.

- 5) Your application states that you will not be taking any deductions on your 2017 tax return.
- 6) You live in Clinton County, New York.
- 7) Your Authorized Representative stated that in updating your application, you were not provided a necessary option to include your monthly income, and believed that a technical issue may have been preventing this.
- 8) The Hearing Officer requested that you provide (1) all earnings statements issued to by each of your employers, [REDACTED], [REDACTED], during the months of October and November 2017, and (2) all earnings statement issued to your spouse by his employer, [REDACTED] during the months of October and November 2017, by January 2, 2018. However, no additional documents were provided by you or your Authorized Representative by January 2, 2018.

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).

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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 of at least 300% but less than 400% of the 2016 FPL, the expected contribution is 9.69% 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 \$16,020.00 for a two-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)).

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

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).

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).

## Household Composition

For purposes of advance premium tax credit (APTC) and cost-sharing reductions (CSR), the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

For purposes of Medicaid eligibility, however, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

## **Legal Analysis**

The first issue is whether NYSOH properly determined that you were eligible to receive an APTC of up to \$67.00 per month, effective December 1, 2017.

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).

The application that was submitted on October 17, 2017 listed an annual household income of \$53,216.54, which consisted of \$22,276.80 you earned from your employment with [REDACTED] between January 1, 2017 and October 15, 2017, \$125.00 you earn from your employment with [REDACTED] once every two weeks, and \$1,064.99 your spouse earns once every two weeks from Clinton County ARC. The eligibility determination relied upon that information.

For purposes of APTC, CSR and the Essential Plan, 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.

You reside in Clinton County, where the second lowest cost silver plan available for an individual through NYSOH costs \$496.57 per month.

An annual income of \$53,216.54 is 332.19% of the 2016 FPL for a two-person household. At 332.19% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or \$429.72 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 an individual in your county (\$496.57 per month) minus your expected contribution (\$429.72 per month), which equals \$66.85 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$67.00 per month in APTC.

The second issue is whether you were properly found not 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 \$53,216.54 is 332.19% of the applicable FPL, NYSOH correctly found you to be not eligible for CSR.

The third issue under review is whether NYSOH properly determined that you 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 \$16,020.00 for a two-person household. Since an annual household income of \$53,216.54 is 332.19% of the 2016 FPL, NYSOH properly found you not eligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that you 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, and to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size.

For Medicaid purposes, you are in a three-person household. You attested that as of your October 17, 2017 application, you live with your spouse, and are pregnant with one child.

On the date of your application, the relevant FPL was \$20,420.00 for a three-person household. Since \$53,216.54 is 260.61% of the 2017 FPL, NYSOH properly found you 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.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is \$3,795.00 per month. Since you did not provide the income documentation as requested by the Hearing Officer prior to the record closing on January 2, 2018, we are unable to review your eligibility for Medicaid on a monthly household income basis.

Because the October 18, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$67.00 per month in APTC, not eligible for CSR, not eligible for the Essential Plan, and not eligible for Medicaid, it is correct and is AFFIRMED.

## **Decision**

The October 18, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** January 05, 2018

## **How this Decision Affects Your Eligibility**

You were eligible for up to \$67.00 in APTC, effective December 1, 2017.

You were not eligible for CSR, the Essential or Medicaid.

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).

This decision relates to your eligibility for financial assistance for 2017 ONLY. You must update your NYSOH application to find out your 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 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 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 18, 2017 eligibility determination notice is AFFIRMED.

You were eligible for up to \$67.00 in APTC, effective December 1, 2017.

You were not eligible for CSR, the Essential or Medicaid.

This decision relates to your eligibility for financial assistance for 2017 ONLY. You must update your NYSOH application to find out your 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:**

[REDACTED]

[REDACTED]

-

## **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.

### **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 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.