



STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 6, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025232

[REDACTED]

Dear [REDACTED],

On February 27, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 5, 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 number 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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DEPARTMENT OF HEALTH
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Decision Date: March 6, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025232

[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 were ineligible for Medicaid, effective January 1, 2018?

Did NYSOH properly determine that you were ineligible to enroll in the Essential Plan, effective January 1, 2018?

Did NYSOH properly determine that you were ineligible to receive advance payments of the premium tax credit (APTC), effective January 1, 2018?

Procedural History

On November 30, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible to purchase a qualified health plan (QHP) at full cost and ineligible for financial assistance, effective January 1, 2018.

Also on November 30, 2017, NYSOH issued a plan enrollment notice confirming that as of November 29, 2017, you were enrolled in a QHP with an enrollment start date of January 1, 2018.

On December 4, 2017, your NYSOH account was updated. Based on that update, NYSOH rendered a preliminary eligibility determination stating that you were not eligible for financial.

Also on December 4, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as you were determined ineligible for financial assistance through NYSOH.

On December 5, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible to purchase a QHP at full cost and ineligible for financial assistance, effective January 1, 2018.

On February 27, 2018, 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) According to your NYSOH account and testimony, you are applying for health insurance for yourself.
- 2) You testified that you want to be determined eligible for financial assistance through NYSOH.
- 3) According to your NYSOH account, you attested that you expect to file a 2018 federal income tax return with the tax status of single and did not expect to claim any dependents on that tax return.
- 4) You testified that you do not reside with anyone.
- 5) According to your NYSOH account and testimony, you expect your yearly income to be approximately \$10,000.00.
- 6) According to your NYSOH account, you were born on November 4, 1947.
- 7) You testified that you applied for Medicaid through Suffolk County Department of Social Services; however, you were determined ineligible because your assets exceeded the maximum limit.
- 8) You testified that you are not currently enrolled in Medicare.
- 9) You testified that you did not enroll in Medicare Part A because you did not meet the work-credit requirement to qualify for free Medicare Part A.
- 10) You testified that the monthly premiums for Medicare Parts A and B would be approximately \$600.00.

11) According to your NYSOH account, you reside in Suffolk County, New York.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Medicaid

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (see N.Y. Soc. Serv. Law § 366(1)(c)).

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).

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Advance Payments of Premium Tax Credit

Advance payments of the premium tax credit (APTC) are available to a person who: (1) is eligible to enroll in a QHP; (2) expects to have a household income greater or equal to 100% but no more than 400% of the applicable federal poverty level (FPL), (3) 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 (4) is not otherwise eligible for minimum essential coverage except through the individual market (see 45 CFR § 155.305(f)(1)).

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 2017 FPL, which is \$12,060.00 for a one-person household (82 Federal Register 8831).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were not eligible to receive Medicaid through NYSOH.

Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives.

The record reflects that you do not reside with anyone and do not expect to claim any dependents on your 2018 federal income tax return. Therefore, you are not a parent or a caretaker relative of a dependent child.

The record reflects that you were born on [REDACTED] and were [REDACTED] when the applications for financial assistance were submitted through NYSOH. Therefore, you were over the allowable age limit for MAGI-based Medicaid.

Since you were over the allowable age limit for MAGI-based Medicaid and not a parent or caretaker relative, NYSOH properly determined that you were not eligible for Medicaid through NYSOH.

The second issue under review is whether NYSOH properly determined that you were not eligible to enroll in the Essential Plan.

One of the non-financial requirements for an individual to be determined eligible to enroll in the Essential Plan is to be [REDACTED] or younger. Again, the record reflects that you were born on [REDACTED] and was [REDACTED]

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■ when the applications were submitted through NYSOH. Therefore, you were over the allowable age limit to enroll in the Essential Plan.

The third issue under review is whether NYSOH properly determined that you were not eligible to receive APTC.

One of the requirements for an individual to be eligible to receive APTC is that their annual household income must fall between 100% and 400% of the applicable FPL.

Based on the application that was submitted on December 4, 2017, you attested to an expected annual household income of \$10,000.00 and the December 5, 2017 eligibility determination notice relied upon that information.

An individual who expects to file a federal income tax return, the household equals the taxpayers and the number of individuals for whom the taxpayer is claiming as a dependent.

You attested that you expect to file a 2018 federal income tax return with the tax status of single and did not expect to claim any dependents on that return. Therefore, you were in a one-person household for purposes of this analysis.

An annual income of \$10,000.00 is 82.92% of the 2017 FPL for a one-person household. Since 82.92% of the FPL is below the income threshold to be considered for APTC, NYSOH correctly determined you to be ineligible for APTC.

Based on the foregoing, NYSOH properly determined you to be ineligible for MAGI-based Medicaid, the Essential Plan, and APTC. Therefore, the December 5, 2017 eligibility determination notice is AFFIRMED.

Decision

The December 5, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 6, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility for or enrollment in health insurance coverage through NYSOH.

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.

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

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The December 5, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility for or enrollment in health insurance coverage through NYSOH.

Legal Authority

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

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।

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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 okyerε 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.

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