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

Notice of Decision

Decision Date: March 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025682 and AP000000025677

[redacted]

Dear [redacted]

On February 14, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 13, 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 Account ID at the top of this notice.

Legal Authority

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).

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

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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).

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

Decision

Decision Date: March 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025682 and AP000000025677

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health properly determine that you were eligible to receive up to $118.00 per month in advance payments of the premium tax credit, effective January 1, 2018?
>
> Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that your oldest child was eligible for Child Health Plus with a $9.00 monthly premium?
>
> Did NY State of Health properly determine that you and your oldest child were not eligible for Medicaid, effective January 1, 2018?

Procedural History

On December 12, 2017, you updated your application for financial assistance.

That day, NY State of Health (NYSOH) issued a preliminary eligibility determination stating that you were eligible to receive up to $118.00 in advance payment of the premium tax credit (APTC) and ineligible to receive cost-sharing reductions and oldest child (child) was eligible for Child Health Plus (CHP) with a $9.00 monthly premium, both effective January 1, 2018.

Also on December 12, 2017, you spoke to NYSOH's Account Review Unit and appealed the preliminary eligibility insofar as you and your child were not eligible for Medicaid.

On December 13, 2017, NYSOH issued an eligibility determination notice, consistent with the preliminary eligibility determination, stating that you were eligible to receive up to $118.00 in APTC and ineligible to receive cost-sharing reductions and your child was eligible for CHP with a $9.00 monthly premium, both effective January 1, 2018. That notice also stated that you and your child were not eligible for Medicaid because your income was over the allowable income limits for that program.

On February 14, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to March 1, 2018, to allow you time to submit supporting documents.

As of March 1, 2018, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) According to your NYSOH account, you expect to file your 2017 taxes with a tax filing status as single and will claim one dependent on that tax return.

2) You testified that you reside in your household with your significant other and two children and that although you expect to file your 2017 taxes with a tax filing status of single, you might claim your two children and your significant other as dependents on your income tax return.

3) You are seeking Medicaid for yourself and your child who was [redacted] years old on the date of your application.

4) The application that was submitted on November 17, 2017, listed annual household income of $50,000.00, consisting of your earnings from employment. You testified that this amount was correct.

5) You testified that your significant other is no longer working.

6) According to your NYSOH account, your income for the month of December 2017 was $4,166.67. You testified that this amount was correct.

7) According to your NYSOH account and testimony, you will not be taking any deductions on your 2017 tax return.

8) You did not submit proof of your household size or household income.

9) According to your NYSOH account and testimony, you and your child live in Rockland County, New York.

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

Applicable Law and Regulations

Household Composition and Tax Filer Requirements

For purposes of and eligibility determination, the household size of an adult individual 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 (42 CFR § 435.603(f)(1)); 26 USC § 36B(d)(1)).

In the case where a child is claimed by one parent as a dependent and who is living with both parents who are not filing a joint tax return (42 CFR § 435.603(f)(2)(ii)), the child's family includes the following persons, if living with the child: (1) the child's parents, (2) the child's spouse, (3) the child's children and siblings under the age of 19, or 21 if a full-time student (42 CFR § 435.603(f)(3)).

In general, household income means the aggregate modified adjusted gross income of every person who is included in the taxpayer's family and is required to file a federal tax return (26 CFR § 1.36B-1(e)).

The IRS determines whether a qualified dependent is required to file an income tax return based on the amount of the dependent's earned and unearned income, marital status, age, student status and whether that dependent is blind. According to the latest final publication, in cases where the dependent is under the age of 65, not blind and earns an income $6,350.00 or higher during the 2017 income tax year (or unearned income in the amount of $1,050 or higher), that dependent is required to file an income tax return for 2017 (IRS Pub. 501).

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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

For annual household income in the range of at least 300% but less than 400% of the 2017 FPL, the expected contribution is 9.56% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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).

<u>Cost-Sharing Reductions</u>

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan 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 qualified health plan (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Child Health Plus

Child Health Plus is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (*see* New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be "eligible for medical assistance"; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child's family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from $9.00 per month to $60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is $9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than $27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

In an analysis of CHP 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 24,600.00 for a four-person household (82 Federal Register 8831).

Medicaid

A person who meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard is eligible for Medicaid benefits (45 CFR § 155.305(c)). One of the non-financial criteria for Medicaid eligibility is the immigration status of the person applying for health insurance. A person is eligible for Medicaid when his or her immigration status is satisfactory and he or she meets all other requirements for 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)).

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-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 $16,240.00 for a two-person household and $24,600.00 for a four-person household (82 Federal Register 8831).

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 under review is whether NYSOH properly determined that you were eligible to receive up to $118.00 per month in advance payments of the premium tax credit, effective January 1, 2018.

Generally, household size of an adult means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a federal tax return, and does not expect to be claimed as a tax dependent by anyone else, includes the taxpayer plus all people the taxpayer expects to claim as dependents.

Additionally, household income consists of the aggregate modified adjusted gross income of every person in the household who is required to file a federal tax return.

You testified that although you expect to file your 2017 taxes with a tax filing status of single, you might claim your two children and your significant other as dependents on your income tax return. Therefore, for purposes of determining

eligibility, you could be four people in your household: yourself, your two children and your significant other.

You further testified that your significant other is no longer working.

As such, the record was held open to allow you time to submit proof of your household size and household income. You did not submit this proof and, therefore, this decision is based on the record as developed at the time of the hearing.

The application that was submitted on December 12, 2017, listed an annual household income of $50,000.00 and the eligibility determination relied upon that information.

According to your NYSOH account, you expect to file your 2017 taxes with a tax filing status as single and will claim one dependent on that tax return. Therefore, for purposes of these analyses, you are in a two-person household.

You reside in Rockland County, where the second lowest cost silver plan available for an individual through NYSOH costs $515.71 per month.

An annual income of $50,000.00 is 307.88% of the 2017 FPL for a two-person household. At 307.88% of the FPL, the expected contribution to the cost of the health insurance premium is 9.56% of income, or $398.00 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 ($515.71 per month) minus your expected contribution ($398.00 per month), which equals $117.71 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $118.00 per month in APTC.

The second issue under review is whether you were properly determined ineligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of $50,000.00 is 307.88% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that your child was eligible to enroll in CHP with a $9.00 per month premium.

As stated earlier, you expect to file your 2017 taxes with a tax filing status as single and will claim one dependent on that tax return and are in a two-person household as a result. However, when calculating household size for a child who is living with both parents but only be claimed by one parent as a tax dependent, the household consists of the child, both parents and any siblings under the age

of 19. On the date of your application, your child resided with you, his father and his sibling. Therefore, NYSOH properly determined your child's eligibility using a four-person household.

A child is eligible to enroll in CHP if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 160% and 222% of the FPL are responsible for a $9.00 per month CHP premium payment. On the date of your application, the relevant FPL was $24,600.00 for a four-person household. Since $50,000.00 is 203.25% of the 2017 FPL, NYSOH properly found your child to be eligible for CHP with a $9.00 per month premium payment.

The fourth issue under review is whether NYSOH properly determined that you and your child were not eligible for Medicaid, effective January 1, 2018.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 and children between the ages of one and 18 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for yourself, and 154% of the FPL for your child, for the applicable family size, respectively.

On the date of your application, the relevant FPL was $16,240.00 for a two-person household and $24,600.00 for a four-person household. Since $50,000.00 is 307.88% of the 2017 FPL for a two-person household, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis. Additionally, because $50,000.00 is 203.25% of the 2017 FPL for a four-person household, NYSOH properly found your child 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.

According to your NYSOH account and testimony, your income for the month of December 2017 was $4,166.67.

To be eligible for Medicaid, you and your child would need to meet the non-financial criteria and have an income no greater than 138% of the FPL for yourself and 154% of the FPL for your child, which respectively is $1,868.00 per month for you and $3,157.00 for your child. Since your NYSOH account and testimony reflects that your income for the month of December 2017 was $4,166.67, you and your child do not qualify for Medicaid based on monthly income as of the date of your application.

Since the December 13, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible to receive up to $118.00 in APTC, ineligible for cost-sharing reductions, and your child was eligible for CHP with a $9.00 monthly premium, and you and your child were ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The December 13, 2017 eligibility determination notice AFFIRMED.

Effective Date of this Decision: March 15, 2018

How this Decision Affects Your Eligibility

You were properly determined eligible for up to $118.00 per month in APTC in 2018.

You were properly determined ineligible for cost-sharing reductions.

Your child remains eligible for CHP with a $9.00 monthly premium.

You and your child were properly determined ineligible for Medicaid.

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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The December 13, 2017 eligibility determination notice AFFIRMED.

You were properly determined eligible for up to $118.00 per month in APTC in 2018.

You were properly determined ineligible for cost-sharing reductions.

Your child remains eligible for CHP with a $9.00 monthly premium.

You and your child were properly determined ineligible for Medicaid.

Legal Authority

We are sending you this notice in accordance with 45 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).

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 नि:शुल्क 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).