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

Notice of Decision

Decision Date: April 18, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026300

[redacted]

[redacted],

On March 2, 2018, you and your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's December 27, 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

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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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: April 18, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000026300

[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 not eligible for Medicaid, effective February 1, 2018?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan?
>
> Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to $318.00 per month in advance payments of the premium tax credit?
>
> Did NYSOH properly determine that you were eligible for cost-sharing reductions?

Procedural History

On December 26, 2017, you submitted an updated application for financial assistance with health insurance through NYSOH. That day, a preliminary eligibility determination was prepared, stating that you were eligible to receive up to $318.00 in advance payments of the premium tax credit (APTC) and cost-sharing reductions, effective February 1, 2018.

Also on December 26, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you were not eligible for Medicaid or other type of financial assistance.

On December 27, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $318.00 in APTC, as well as cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective February 1, 2018. That notice also stated that you were not eligible for Medicaid because your annual household income was over the allowable income limits for that program. That notice also stated that you were not eligible for the Essential Plan because to be eligible for the essential plan, you must be under age 65, not eligible to enroll in other coverage, and have income below $32,480.00.

On March 2, 2018, 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 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 tax return for 2018 with a tax filing status of Head of Household (with qualifying individual). You will claim your domestic partner, [redacted], as a dependent on that tax return.

2) You are seeking insurance for yourself.

3) The application that was submitted on December 26, 2017 listed annual household income of $29,124.00, consisting of a retirement pension of $2,427.00 a month. You testified that this amount was correct.

4) You testified and the record reflects that [redacted] receives $290.00 a month in Social Security disability benefits and will not be filing a tax return.

5) Your application states that you will not be taking any deductions on your 2018 tax return.

6) You testified that you retired from employment at [redacted] in February 2014 after [redacted] of employment.

7) According to your NYSOH account and your testimony, you are enrolled in MVP Health Care, sponsored by your former employer, with plan start

date of January 1, 2018 through December 31, 2018. The record reflects that the monthly premium for this coverage for a single person is $295.81.

8) According to your NYSOH account and your testimony, you were previously determined eligible for Medicaid, and NYSOH was reimbursing you of the monthly premium for your MVP Health Plan from May 1, 2017 to December 2017.

9) Your application states that you live in Ontario County.

10) You testified that you have multiple medical problems and that the expenses of the MVP Health Plan you have as a retiree, including the co-payments and deductibles, are such that the plan is not affordable and you are overwhelmed with medical costs. You would like to be eligible for Medicaid or to have your premiums reimbursed as you had last year.

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

Applicable Law and Regulations

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 federal poverty level (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 December 26, 2017 application, that was the 2017 FPL, which is $16,240.00 for a two-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).

Affordability of Employer-Sponsored Insurance

Regarding eligibility for the premium tax credit, a retired employee who may enroll in an employer-sponsored health insurance plan is considered eligible for minimum essential coverage only if that plan "is affordable and provides minimum value" (26 CFR § 1.36B-2(c)(3)(i), (iv)).

An eligible employer-sponsored plan is "affordable" if the portion of the annual premium that the employee or related individual must pay for self-only coverage does not exceed the expected contribution (26 USC § 36B(c)(2)(C)(i)). 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).

An individual is eligible to enroll in the Essential Plan, even if that individual is also eligible to enroll in an employer-sponsored health plan, or has in fact enrolled in such a plan, if that health plan is unaffordable as described above (42 USC § 18051(e)(1)(C), 42 CFR § 600.305(a)(3)(ii), 26 USC § 36B(c)(2)(C)(i)).

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 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 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

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)).

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 Fed. Reg. 8831).

For annual household income in the range of at least 150% but less than 200% of the 2017 FPL, the expected contribution is between 4.03% and 6.34% 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).

Cost-Sharing Reductions

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)).

Legal Analysis

The first 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 December 26, 2017 application, the relevant FPL was $16,240.00 for a two-person household. Since $29,124.00 is 179.33% 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.

According to your NYOSH account and your testimony, you receive a monthly retirement pension of $2,427.00.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,868.00 per month. Since the record reflects that you receive a monthly pension of $2,427.00, you did not qualify for Medicaid based on monthly income as of the date of your application.

The second issue under review is whether NYSOH properly determined you were ineligible for the Essential Plan.

You testified and the record reflects that you are eligible for and are covered by MVP Health Plan as a retiree from your employment at the [redacted]. You contend that without further financial assistance, this coverage is not affordable.

Generally, if you are enrolled in an employer-sponsored insurance plan outside NYSOH, you are not eligible to enroll in the Essential Plan. However, if such a plan is considered "unaffordable," that bar does not apply.

Your expected household income for 2018 is $29,124.00, which is 179.33 percent of the applicable FPL. Therefore, you would be expected to contribute no more than 5.39% of your annual income towards health insurance.

You provided evidence that your monthly premium for coverage with MVP is $295.81, or $3,549.72 per year. With an expected household income of $29,124.00 per year, that annual premium constitutes over 12% of your household income, well over 5.39%.

The Appeals Unit finds that your coverage through MVP is not considered affordable, and that therefore eligibility for the Essential Plan is not barred.

Once the non-financial requirements are met, in order to be eligible for the Essential Plan, you must 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 $16,240.00 for a two-person household. Since an annual household income of $29,124.00 is 179.33% of the 2017 FPL, you would be eligible for the Essential Plan on a financial basis, with a $20.00 monthly premium.

Therefore, the Appeals Unit finds that you are eligible for the Essential Plan.

The third issue is whether NYSOH properly determined that you were eligible for up to $318.00 per month in APTC, effective February 1, 2018.

The application that was submitted on December 26, 2017 listed an annual household income of $29,124.00 and the eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2018 income tax return as Head of Household (with qualifying individual) and will claim your domestic partner, [redacted], as a dependent on that tax return.

You reside in Ontario County, where the second lowest cost silver plan available for an individual through NYSOH costs $449.12 per month.

An annual income of $29,124.00 is 179.33% of the 2017 FPL for a two-person household. At 179.33% of the FPL, the expected contribution to the cost of the health insurance premium is 5.39% of income, or $130.57 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 ($449.12 per month) minus your expected contribution ($130.81 per month), which equals $318.31 per month. Therefore, rounding to the nearest dollar, NYSOH determined you to be eligible for up to $318.00 per month in APTC.

However, an individual is not eligible to receive APTC if he is eligible to enroll in the Essential Plan. Since you are eligible for the Essential Plan, you are not eligible for APTC.

The last issue is whether you were properly determined eligible for cost-sharing reductions. Cost-sharing reductions are only available to a person who is eligible to receive APTC. Therefore, you are not eligible for cost-sharing reductions.

The December 27, 2017 eligibility determination notice stated that you were eligible for up to $318.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid.

The Appeals Unit finds that these findings were incorrect, and the December 27, 2017 eligibility determination notice is therefore MODIFIED to reflect that you are ineligible to receive APTC, cost-sharing reductions, and Medicaid, and that you are eligible for the Essential Plan.

Your case is RETURNED to NYSOH to assist you in selecting an Essential Plan.

Decision

The December 27, 2017 eligibility determination notice is MODIFIED to reflect that you are eligible to enroll in the Essential Plan, with a $20.00 monthly premium, and ineligible for APTC, cost-sharing reductions, and Medicaid.

Your case is RETURNED to NYSOH to assist you in selecting an Essential Plan.

Effective Date of this Decision: April 18, 2018

How this Decision Affects Your Eligibility

You are eligible to enroll in the Essential Plan, as early as February 1, 2018.

You are ineligible for APTC, cost-sharing reductions, and Medicaid.

Your case is RETURNED to NYSOH to assist you in selecting an Essential Plan, if you so choose.

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 case 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
  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

You are eligible to enroll in the Essential Plan.

The December 27, 2017 eligibility determination notice is MODIFIED to reflect that you are eligible to enroll in the Essential Plan, with a $20.00 monthly premium, and ineligible for APTC, cost-sharing reductions, and Medicaid.

Your case is RETURNED to NYSOH to assist you in selecting an Essential Plan.

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 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).