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

Notice of Decision

Decision Date: March 21,2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026506

[redacted]

Dear [redacted],

On March 1, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 28, 2017 and January 14, 2018 eligibility determination notices.

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 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 21,2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026506

[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 eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018?
>
> Did NYSOH properly determine that you were eligible to receive an advance premium tax credit of up to $438.00 per month and, if you selected a silver-level plan, eligible for cost-sharing reductions, effective February 1, 2018?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On December 14, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2017. On that same date, you enrolled in a Medicaid Managed Care (MMC) plan with such coverage beginning January 1, 2017.

On October 28, 2017, NYSOH issued a renewal and eligibility determination notice stating that based on information about you from state and federal data sources obtained as of October 7, 2017, you were found eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

On November 17, 2017, NYSOH issued a disenrollment notice confirming that your Medicaid coverage would end effective December 31, 2017.

Also on November 17, 2017, NYSOH issued an enrollment notice confirming your enrollment in an Essential Plan as of November 16, 2017, with such coverage beginning effective January 1, 2018.

On December 29, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not found eligible for Medicaid.

On January 13, 2018, NYSOH redetermined your eligibility for financial assistance with health insurance.

On January 14, 2018, NYSOH issued an eligibility determination notice stating that you were found eligible to receive an advance premium tax credit (APTC) of up to $438.00 per month, effective February 1, 2018. You were also found not eligible for either the Essential Plan or Medicaid since your annual household income was over the allowable income limits for those programs.

Also on January 14, 2018, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end effective January 31, 2018.

On March 1, 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 support 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. You will claim your child as your sole dependent on that tax return.

2) You are seeking insurance for yourself only, since your child is already enrolled in Child Health Plus.

3) The annual redetermination of your eligibility on October 7, 2017 used a household income of $24,960.00, which consisted of $12.00 per hour you received from your employment with [redacted], over a 40-hour work week. You testified that this amount was correct as of October 2017. You further testified that have since left [redacted] and began working at [redacted] in January 2018.

4) You testified that you are now employed by [redacted]., and receive $16.00 per hour and typically work a 40-hour workweek. Your eligibility was redetermined by NYSOH on January 13, 2018 using an updated annual household income of $33,280.00.

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

6) You live in Ulster County, New York.

7) You testified that you were seeking to remain enrolled in Medicaid since you cannot afford the cost and co-pays associated with either the Essential Plan or Medicaid.

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

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

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 200% but less than 250% of the 2017 FPL, the expected contribution is between 6.34% and 8.10% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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)).

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).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 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 for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

The record reflects NYSOH redetermined your eligibility based on information obtained about you from state and federal sources as of October 7, 2017. The redetermination on October 7, 2017 listed an annual household income of $24,960.00, which consisted of $12.00 per hour you received from your employment with [redacted] over a 40-hour work week. You testified that this amount was correct as of October 2017. The eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2018 income taxes as head of household and will claim you child as your sole dependent on that tax return.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) 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 $24,960.00 is 153.69% of the 2017 FPL, NYSOH properly found you to be eligible for the Essential Plan, effective January 1, 2018.

Therefore, the October 28, 2017 eligibility determination notice is AFFIRMED.

The second issue under review NYSOH properly determined that you were eligible to receive an advance premium tax credit of up to $438.00 per month and, if you selected a silver-level plan, eligible for cost-sharing reductions, effective February 1, 2018.

The record reflects that your eligibility was redetermined by NYSOH on January 13, 2018, based on an annual household income of $33,280.00, which consisted of $16.00 per hour you earned from [redacted] over typical work a 40-hour workweek. You testified that these figures were accurate.

You reside in Ulster County, where the second lowest cost silver plan available for an individual through NYSOH costs $618.25 per month.

An annual income of $33,280.00 is 204.93% of the 2017 FPL for a two-person household. At 204.93% of the FPL, the expected contribution to the cost of the health insurance premium is 6.51% of income, or $180.64 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 ($618.25 per month) minus your expected contribution ($180.64 per month), which equals $437.61 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $438.00 per month in APTC.

CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of $33,280.00 is 204.93% of the applicable FPL, NYSOH correctly found you to be eligible for CSR.

The third issue under review is whether NYSOH properly found you not eligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $33,280.00 is 204.93% 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.

You provided credible testimony that you are paid on a bi-weekly basis and typically receive $1,280.00 once every two weeks and $2,560.00 per month.

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 your testimony reflects that you earned at least $2,560.00 in January 2018, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the January 14, 2018 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to $438.00 per month in APTC, eligible for CSR, and not eligible for Medicaid, it is correct and is AFFIRMED.

Decision

The October 28, 2017 eligibility determination notice is AFFIRMED

The January 14, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 21,2018

How this Decision Affects Your Eligibility

You were eligible for the Essential Plan between January 1, 2018 and January 31, 2018.

You were eligible for an APTC of up to $438.00 per month and, if you selected a silver-level plan, eligible for CSR, effective February 1, 2018.

You are not eligible for Medicaid.

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 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

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).

Summary

The October 28, 2017 eligibility determination notice is AFFIRMED

The January 14, 2018 eligibility determination notice is AFFIRMED.

You were eligible for the Essential Plan between January 1, 2018 and January 31, 2018.

You were eligible for an APTC of up to $438.00 per month and, if you selected a silver-level plan, eligible for CSR, effective February 1, 2018.

You are not eligible for Medicaid.

Legal Authority

We are issuing this determination 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).