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

# Notice of Decision

Decision Date: April 24, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029020

[redacted]

[redacted],

On April 16, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 16, 2018 eligibility determination.

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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DEPARTMENT OF HEALTH
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# Decision

Decision Date: April 24, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029020

[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 not eligible to receive advance payments of the premium tax credit (APTC) toward the cost of a qualified health plan (QHP), as of February 15, 2018?
>
> Did NYSOH properly determine that your child was eligible to enroll in Child Health Plus (CHP) at full cost, effective March 1, 2018?

## Procedural History

On February 22, 2017, NYSOH issued a notice of eligibility determination stating you and your child were eligible for Medicaid, effective March 1, 2017. You were subsequently enrolled into a Medicaid Managed Care plan, beginning April 1, 2017.

On January 2, 2018, NYSOH issued a renewal notice stating that it was time to renew your application for health insurance for 2018. That notice stated that, based on information obtained from state and federal data sources, NYSOH could not determine whether you and your child qualified for financial help paying for your health insurance. The notice directed you to update your NYSOH application between January 16, 2018 and February 15, 2018 so that a decision could be made as to whether you and your child were eligible for financial assistance.

On February 15, 2018, you updated your NYSOH application.

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On February 16, 2018, NYSOH issued a notice of eligibility determination stating you were eligible to enroll in a QHP at full cost through NYSOH, effective March 1, 2018. The notice stated you did not qualify for any financial assistance because the income in your application was over $64,960.00, which is above the allowable income limit for financial assistance. The notice also stated your child was eligible to enroll in a CHP plan at full cost, effective March 1, 2018, and not eligible for financial assistance because the income in your application was over $64,960.00.

That same day, NYSOH issued a disenrollment notice, stating your enrollment in your Medicaid Managed Care plan was ending, effective March 31, 2018, and your child's enrollment was ending, effective February 28, 2018.

Also on February 16, 2018, you spoke to NYSOH's Account Review Unit and appealed the February 16, 2018 eligibility determination, insofar as you and your child were not eligible for financial assistance with the cost of your health insurance. You also requested Aid to Continue, pending the outcome of your appeal.

On March 2, 2018, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid for a limited time, effective April 1, 2018, and your child was eligible for Medicaid for a limited time, effective March 1, 2018. This was because your request for Aid to Continue was granted, pending the outcome of your appeal.

Also on March 2, 2018, NYSOH issued a notice of enrollment, stating you were enrolled in a Medicaid Managed Care plan, beginning April 1, 2018, and your child was enrolled in a Medicaid Managed Care plan beginning March 1, 2018. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On April 16, 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) You testified that you expect to file your 2018 taxes with a tax filing status of head of household. You will claim one dependent on that tax return.

2) You are seeking insurance for yourself and your child.

3) On February 15, 2018, you updated your NYSOH application, and indicated that your annual expected household income for 2018 was $70,000.00, consisting of income you earn from employment.

4) You testified this amount is correct and that you are a salaried employee, paid bimonthly.

5) You testified you will begin contributing to a 401K soon, but that deductions have not started coming out of your paycheck yet.

6) You testified you do not plan to take any deductions on your tax return.

7) Your application states that you live in [redacted].

8) You testified you cannot afford to pay $200.00 a month for CHP coverage, on top of at least $400.00 a month for coverage for yourself.

9) You testified your child has medical needs for which you want to ensure she has coverage.

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 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 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).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on their 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).

Child Health Plus

CHP 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 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)).

The CHP premium is $15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than $54.00 per month per family (NY PHL § 2510(9)(d)(iii)).

The CHP premium is $30.00 per month for a child whose family household income is between 251% and 300% of the FPL, but no more than $90.00 per month per family (NY PHL § 2510(9)(d)(iv)).

The CHP premium is $45.00 per month for a child whose family household income is between 301% and 350% of the FPL, but no more than $135.00 per month per family (NY PHL § 2510(9)(d)(v)).

The CHP premium is $60.00 per month for a child whose family household income is between 351% and 400% of the FPL, but no more than $180.00 per child (NY PHL § 2510(9)(d)(vi)).

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 2018 FPL, which is $16,460.00 for a two-person household (83 Fed. Reg. 2642).

## Legal Analysis

The first issue under review is whether NYSOH properly determined that you do not qualify to receive APTC to help pay for the cost of your QHP premium, as of your February 15, 2018 application.

The application that was submitted on February 15, 2018 listed an annual household income of $70,000.00, and the eligibility determination relied upon that information. You testified that this amount is accurate, and that you are a salaried employee.

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

An annual income of $70,000.00 is 431.03% of the 2017 FPL for a two-person household. APTC are available to individuals with income below 400% of the applicable FPL. Since an income of $70,000.00 is 431.03% of the 2017 FPL, NYSOH properly determined you to be ineligible for financial assistance with the cost of health insurance, based on the information in your application.

The second issue under review is whether NYSOH properly determined that your child was eligible to enroll in CHP at full cost, effective March 1, 2018.

A child is eligible to enroll in CHP with a subsidy if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Children with a household income above 400% of the applicable FPL are eligible to enroll in CHP coverage, but must pay the full cost of the premium.

On the date of your application, the relevant FPL was $16,460.00 for a two-person household. Since an annual income of $70,000.00 is 425.27% of the 2018 FPL, NYSOH properly determined your child to be ineligible for a CHP premium subsidy, and eligible to enroll in a CHP plan at full cost, effective March 1, 2018.

Therefore, the February 16, 2018 eligibility determination, stating you were eligible to enroll in a full cost QHP, and your child is eligible to enroll in CHP at full cost, was correct and must be AFFIRMED.

## Decision

The February 16, 2018 eligibility determination notice is AFFIRMED.

## Effective Date of this Decision: April 24, 2018

## How this Decision Affects Your Eligibility

You were eligible to enroll in a QHP at full cost, as of your February 15, 2018 application, and not eligible to receive financial assistance with the cost of a QHP premium.

Your child was eligible for CHP at full cost, effective March 1, 2018, based on the income information you provided.

You may update your NYSOH application at any time if your income changes.

## 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

P.O. Box 11729
Albany, NY 12211

- By fax: 1-855-900-5557

## Summary

The February 16, 2018 eligibility determination notice is AFFIRMED.

You were eligible to enroll in a QHP at full cost, as of your February 15, 2018 application, and not eligible to receive financial assistance with the cost of a QHP premium.

Your child was eligible for CHP at full cost, effective March 1, 2018, based on the income information you provided.

You may update your NYSOH application at any time if your income changes.

## 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)**

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).

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।

**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).

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