



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

Notice of Decision

Decision Date: May 30, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000030139



Dear [REDACTED]

On May 8, 2018, you and your spouse appeared by telephone at a hearing on your appeal of NY State of Health's March 14, 2018 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).

This page intentionally left blank.



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

Decision

Decision Date: May 30, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000030139



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 ineligible for advanced payments of the premium tax credit and the Essential Plan, effective April 1, 2018?

Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On March 13, 2018, NY State of Health (NYSOH) received your application for health insurance. That day, a preliminary eligibility determination was prepared stating that you were eligible to enroll in a qualified health plan at full cost.

Also on March 13, 2018, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not eligible for financial assistance.

On March 14, 2018, NYSOH issued an eligibility determination notice based on the information contained in the March 13, 2018 application, stating you were eligible to purchase a qualified health plan at full cost, effective April 1, 2018. The notice also stated that you were not eligible to receive advance premium tax credits (APTC) or eligible for the Essential Plan because you were already enrolled in or eligible to enroll in an employer-sponsored health insurance plan

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).

that is affordable and meets minimum value. The notice further stated that you were not eligible for Medicaid because your household income was over the allowable income limit for that program.

On May 8, 2018, you and your spouse had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and held open until May 23, 2018 to allow you time to submit supporting documentation.

As of May 23, 2018, the NYSOH's Appeals Unit did not receive any documents from you and none was 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) As of your March 13, 2018 application, you were seeking health insurance only for yourself.
- 2) The application that was filed on March 13, 2018, listed an annual household income of \$38,479.00, consisting of income you receive from your employment. You testified that this was correct at that time.
- 3) You testified, and your March 13, 2018 application indicates, that you were pregnant with one child with a due date of [REDACTED]
- 4) You testified, and your March 13, 2018 application indicates, that you were enrolled into coverage under an employer-sponsored health insurance plan effective January 1, 2018, and as of the date of the hearing this insurance was still effective.
- 5) You testified, and the March 13, 2018 application indicates, that this coverage includes outpatient and inpatient services.
- 6) Your March 13, 2018 application indicates that you pay \$87.74 every two weeks for health insurance through your employer.
- 7) You testified that you are unable to afford the high deductible associated with your employer-sponsored health insurance, and would like to be eligible to enroll in a program that is more affordable and provides better coverage.

- 8) You testified that since you were pregnant at the time of your March 13, 2018 application, that you think you should be found eligible for Medicaid.

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

Applicable Law and Regulations

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

Advance Payments of the Premium Tax Credit

An APTC is 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 Federal Poverty Line (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 (45 CFR § 155.305(f)).

Employer-Sponsored Insurance

An employee who may enroll in an employer-sponsored health insurance plan and an individual who may enroll in the plan because of a relationship to the employee are considered eligible for minimum essential coverage as long as the plan “is affordable and provides minimum value” (26 CFR § 1.36B-2(c)(3)(i)).

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 required contribution. The required contribution percentage is 9.56% of the employee’s household income for 2018 (26 CFR §1.36B-2(c)(3)(v), 26 CFR §1.36B-2T, IRS Rev. Proc. 2017-36).

Medicaid for Pregnant Women

Medicaid can be provided through the Marketplace 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)), N.Y. Soc. Serv. Law § 366(1)(b)).

In New York, a pregnant woman is eligible for Medicaid at a household income of 223% of the federal poverty level (FPL) for the applicable family size (42 CFR §435.116 (c)(2); NY Department of Social Services Administrative Directive 13ADM-03).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

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 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 were ineligible for APTC and the Essential Plan, effective April 1, 2018.

In the eligibility determination notice issued on May 19, 2017, NYSOH found you ineligible for APTC and the Essential Plan because you were either enrolled in an employer-sponsored health insurance, or you were eligible to enroll in employer-sponsored health insurance that is affordable and meets minimum value.

An employee or a related individual to the employee, who is eligible to enroll in an employer-sponsored health insurance plan that is affordable and provides minimum value, is not eligible for APTC or the Essential Plan through NYSOH.

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).

During the hearing, you testified that you are enrolled in employer-sponsored health insurance. However, you testified that your insurance through your employer is unaffordable to you.

Employer-sponsored health insurance coverage is considered to be affordable if it costs no more than 9.56% of the household income. NYSOH uses the amount you would pay for self-only coverage through an employer to calculate whether or not a plan is affordable.

The application that was filed on March 13, 2018 listed an expected annual household income of \$38,479.00, consisting of income you earn from your employment. You testified that this amount was correct at the time you filed your application.

Therefore, your employer sponsored health insurance coverage would be unaffordable to you if the premium cost associated with the self-only plan costs more than \$3,678.59 per year ($\$38,479.00 \times 9.56\%$).

The Hearing Officer left the record open until May 23, 2018, to allow you time to submit proof of your employer-sponsored health insurance premium for a self-only plan. However, as of the date of this decision, you have not provided documentation which indicates the amount that your employer-sponsored health insurance premium for a self-only plan would be. Therefore, without sufficient documentation to verify the cost of a self-only plan through your employer-sponsored health insurance, the NYSOH's Appeals Unit must use the information that is currently available in your NYSOH account to make a decision on the appeal.

The March 13, 2018 application indicates that you are enrolled in a self-only plan through your employer and you pay a biweekly cost of \$83.74. This results in an annual premium cost of \$2,177.24 ($\83.74×26 weeks). Since your annual premium cost for a self-only plan is less than \$3,678.59, it is considered affordable by NYSOH.

Since you have health insurance coverage through your employer that costs less than 9.56% of your household income and there is no indication in the record that the coverage does not provide minimum value to you, NYSOH properly determined that you are ineligible for APTC and the Essential Plan, based on the information in you provided in your application.

The second issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid can be provided through NYSOH to pregnant women who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 223% of the FPL for the applicable family size.

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).

Generally, for purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and the number of children she expects to deliver. Therefore, at the time of the March 13, 2018 application, you were in a two-person household because you lived alone and were pregnant with one child.

On the date of your application, the relevant FPL was \$16,420.00 for a two-person household. Since \$38,479.00 is 233.78% of the 2018 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. To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is \$3,059.00 per month.

The Hearing Officer left the record open until May 23, 2018, to allow you time to submit income documentation for the month of March 2018. However, by the end of the day on May 23, 2018, there were no income documents received by the NYSOH's Appeals Unit, nor were there any income documents viewable on your NYSOH account. Since there is no other reliable income documentation indicating what your income was for the month of March 2018, the NYSOH's Appeals Unit must rely upon the system calculated income amount for this decision.

The application that was submitted on March 13, 2018, listed an annual expected income of \$38,479.00 and the eligibility determination relied upon that information. You testified that the income amount you provided in your March 13, 2018 application was correct at the time. Therefore, using the annual expected income, your income for March 2018 was calculated to be \$3,206.58, which is greater than the maximum allowable month income to be eligible for Medicaid based on monthly income. As a result, you do not qualify for Medicaid based on monthly income as of the date of the March 13, 2018 application.

Since the March 14, 2018 eligibility determination notice properly stated that, based on the information you provided, you were eligible to enroll in a qualified health plan at full cost, ineligible to receive APTC, ineligible for the Essential Plan, and ineligible for Medicaid, it is correct and is **AFFIRMED**.

Decision

The March 14, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 30, 2018

How this Decision Affects Your Eligibility

You were properly determined eligible for a full price qualified health plan in 2018.

NYSOH properly determined that you were ineligible to receive APTC and ineligible to enroll into the Essential Plan because you were already enrolled in or eligible to enroll in an employer-sponsored health insurance plan that is affordable and meets minimum value.

NYSOH properly determined that you were ineligible for Medicaid because your household income is over the household income limit(s) to be eligible for that program.

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

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).

- 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 May 20, 2017 eligibility determination is **AFFIRMED**.

You were properly determined eligible for a full price qualified health plan in 2018.

NYSOH properly determined that you were ineligible to receive APTC and ineligible to enroll into the Essential Plan because you were already enrolled in or eligible to enroll in an employer-sponsored health insurance plan that is affordable and meets minimum value.

NYSOH properly determined that you were ineligible for Medicaid because your household income is over the household income limit(s) to be eligible for that program.

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).

Legal Authority

We are issuing this determination 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:



Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerε kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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).