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

Notice of Decision

Decision Date: May 29, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030150

[redacted]

Dear [redacted]

On May 9, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 10, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 29, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000030150

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to $150.00 in advance payments of the premium tax credit (APTC), and not eligible for Medicaid, effective April 1, 2018?

Procedural History

On April 26, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid, effective as of April 1, 2017.

On May 1, 2017, NYSOH received your updated application for health insurance, in which you indicated that your spouse was now seeking insurance.

On May 2, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. You were directed to provide proof of household income by May 16, 2017, to confirm your household's eligibility for financial assistance.

Also on May 2, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until March 31, 2018, because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of May 1, 2017.

Also on May 2, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective June 1, 2017.

On May 3, 2017, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid and your spouse was newly eligible for Medicaid, effective May 1, 2017.

Also on May 9, 2017, NYSOH issued a plan enrollment notice, stating that your household was enrolled in a Medicaid Managed Care plan, effective June 1, 2017.

On August 7, 2017, NYSOH received your updated application for health insurance.

On August 8, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were no longer eligible for Medicaid. However, your Medicaid coverage would continue until March 31, 2018, and your spouse's Medicaid coverage would continue until August 31, 2018, because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of August 1, 2017.

On February 2, 2018, NYSOH issued a renewal notice, stating that based on information from federal and state sources, NYSOH could not make a decision about whether your household qualified for financial help paying for your health insurance coverage. You were directed to update your application by March 15, 2018.

On March 9, 2018, NYSOH received your updated application for health insurance.

On March 10, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $150.00 in APTC, effective April 1, 2018. The notice also informed you must confirm your health plan selection by June 29, 2018 and, if you miss this date, you cannot get coverage for 2018. That same notice also stated that your spouse was no longer eligible for Medicaid but his Medicaid coverage would continue until August 31, 2018, because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible.

Also on March 10, 2018, NYSOH issued a disenrollment notice stating that your enrollment in a Medicaid Managed Care plan would end on April 30, 2018.

On March 13, 2018, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were determined not eligible for Medicaid.

On May 9, 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 are seeking Medicaid coverage for yourself, because your spouse has Medicaid coverage and you cannot afford monthly premiums.

2) According to your NYSOH account, you have not selected a qualified health plan as of the date that this Decision is being issued.

3) You expect to file your 2018 federal income tax return as married filing jointly, and claim two dependents.

4) According to your NYSOH account, you were first determined eligible for Medicaid effective April 1, 2017, and were subsequently determined eligible for Medicaid effective May 1, 2017.

5) According to your NYSOH account, your spouse was first determined eligible for Medicaid effective May 1, 2017.

6) According to the April 25, 2017 and May 1, 2017 applications, you attested to an expected annual household income of $0.00. You testified that the information in all your applications is correct.

7) According to the August 7, 2017 application, you attested to an increased expected household income of $67,530.00.

8) According to the March 9, 2018 application, you attested to an expected household income of $62,400.00.

9) You confirmed that you do not have an income, and that your spouse earns $1,200.00 per week.

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

11) Your application states that you live in [redacted], NY.

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 $24,600.00 for a four -person household (82 Federal Register 8831).

For annual household income in the range of at least 250% but less than 300% of the 2017 FPL, the expected contribution is between 8.1% and 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).

Medicaid for Adults between the Ages of 19 and 65

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), 435.911(b)(1), 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 2018 FPL, which is $25,100.00 for a four-person household (83 Fed. Reg. 2642).

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as "continuous coverage" and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

Legal Analysis

The first issue under review is whether NYSOH properly determine that you were eligible to receive up to $150.00 in APTC, and no longer eligible for Medicaid, effective April 1, 2018.

You testified that you are seeking Medicaid coverage because you spouse currently has Medicaid, and you cannot afford monthly premiums.

NYSOH issued an eligibility determination notice on May 3, 2017, stating that you were eligible for Medicaid effective May 1, 2017. That determination is not under review.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.”

Credible evidence confirms that you were eligible for Medicaid effective May 1, 2017, and that even though your estimated annual income increased, you remained enrolled in Medicaid for the remainder of your 12-month eligibility period as continuous coverage, which ended on April 30, 2018. This is evidenced by the March 10, 2018 disenrollment notice issued by NYSOH, which states that your enrollment in a Medicaid Managed Care plan would end on April 30, 2018.

You submitted an updated application on March 9, 2018. That application listed an annual household income of $62,400.00, and the eligibility determination relied upon that information.

You are in a four-person household for purposes of this analysis. This is because you expect to file your 2018 income tax return as married filing jointly and will claim two dependents on that tax return.

You reside in Onondaga County, where the second lowest cost silver plan available for an individual through NYSOH costs $576.12 per month.

An annual income of $62,400.00 is 253.66% of the 2017 FPL of $24,600.00 for a four-person household. At 253.66% of the FPL, the expected contribution to the cost of the health insurance premium in 2018 is 8.21% of income, or $426.92 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 ($576.12 per month) minus your expected contribution ($426.92 per month), which equals $149.20 per month. Therefore, rounding up to the nearest dollar, NYSOH correctly determined you to be eligible for up to $150.00 per month in APTC.

The second issue under is whether NYSOH properly determined that you were ineligible for Medicaid, as of April 1, 2018.

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 $25,100.00 for a four-person household. Since an annual household income of $62,400.00 is

248.61% of the 2018 FPL of $25,100.00, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since NYSOH properly determined that your Medicaid continuous coverage period had ended and that you were eligible to receive up to $150.00 in APTC and ineligible for Medicaid, based on the information provided in your application, the May 10, 2018 eligibility determination notice is correct and is AFFIRMED.

It is noted that, according to your NYSOH account, you have not selected a qualified health plan with APTC as of the date of this Decision. According to the March 10, 2018 eligibility determination notice, you have until June 29, 2018, to confirm your health plan selection. If you miss this date, you cannot get coverage for 2018. You can find more information about choosing a health plan in the "Health Plan Enrollment" section of the March 10, 2018 eligibility determination notice. You will receive written confirmation from NY State of Health once you have selected a plan.

Decision

The March 10, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 29, 2018

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on May 1, 2017, properly continued until and ended as of April 30, 2018.

You were properly determined eligible to receive up to $150.00 per month in APTC as of May 1, 2018, and ineligible for Medicaid.

This Decision does not change your eligibility.

You have until June 29, 2018, to confirm your health plan selection, if you so choose.

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.

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).

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 March 10, 2018 eligibility determination notice is AFFIRMED.

Your Medicaid coverage, which began on May 1, 2017, properly continued until and ended as of April 30, 2018.

You were properly determined eligible to receive up to $150.00 per month in APTC as of May 1, 2018, and ineligible for Medicaid.

This Decision does not change your eligibility.

You have until June 29, 2018, to confirm your health plan selection, if you so choose.

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 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 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).