



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

Notice of Decision

Decision Date: June 10, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000001476

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

On February 17, 2015, you appeared by telephone at a hearing on your appeal of NY State of Health Marketplace's December 6, 2014, 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 at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 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).

This page intentionally left blank.



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

Decision

Decision Date: June 10, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000001476

[REDACTED]
[REDACTED]
[REDACTED]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Did the Marketplace properly determine that you were not eligible for Medicaid effective January 1, 2015?

Did the Marketplace properly determine that you were eligible to receive up to \$207.00 monthly of advance premium tax credit as of December 6, 2014?

Did the Marketplace properly determine that you were eligible for cost-sharing reductions as of December 6, 2014?

Procedural History

On January 21, 2014, the Marketplace received your application for health insurance. The Marketplace prepared a preliminary eligibility determination stating that you are eligible to receive Medicaid.

On February 20, 2014, the Marketplace issued an eligibility determination stating that you are Medicaid eligible effective January 1, 2014. The Marketplace also issued a notice stating that your insurance coverage through Medicaid will begin January 1, 2014, and enrollment with CDPHP will begin March 1, 2014.

On December 5, 2014, you reapplied for health insurance through the Marketplace. On December 6, 2014, the Marketplace issued an eligibility determination stating: You are eligible to receive \$207.00 monthly of advance premium tax credit; eligible for cost-sharing reductions; and not eligible for Medicaid effective January 1, 2015.

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).

On January 15, 2015, you spoke with the Marketplace's Account Review unit and appealed that determination.

On February 17, 2015, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. The record was developed during that 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 are applying for health insurance through the Marketplace for yourself only.
2. Your marital status is divorced.
3. You testified that you currently reside with your two children.
4. You testified that you plan on filing a 2015 federal income tax return.
5. You testified that you plan on filing a U.S. Income Tax Return with the tax status of Head of Household (with qualifying individual) and will claim one of your children as a dependent on your 2015 federal income tax return.
6. According to your January 9, 2015 Marketplace application, your 2015 expected annual household income is \$28,073.50, which represents your expected earned income.
7. You currently reside in Albany County, NY.
8. You testified that as of December 31, 2014, your Medicaid coverage has only been effective for ten months and should continue until February 28, 2015.
9. You have enrolled in MVP Premier Plus Plan and Managed Dental Plans effective January 1, 2015. You want to be reimbursed for any health care costs incurred during the period of January 1, 2015, until March 1, 2015, that would have been covered by Medicaid (Appellant Exhibit 1).
10. Your CDPHP Medicaid Managed Care Plan had an effective coverage period of March 1, 2014, until December 31, 2014 (Appellant Exhibit 1).
11. You state that because of your change in income as of October 2014, you no longer qualify for Medicaid after the annual coverage period (Appellant Exhibit 1).

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).

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 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 that is at or below 138% of the federal poverty 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)).

The agency may make eligibility for Medicaid effective on the first day of a month if an individual was eligible at any time during that month (42 CFR § 435.915(b)).

Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage offered through Medicaid Managed Care, even if the adult loses Medicaid eligibility because of any changes or updates they make to their Marketplace 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 twelve-month period. This twelve-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 (see 42 CFR § 435.916; N.Y. Soc. Serv. Law § 366(4)(c)).

Advance Premium Tax Credit:

The advance premium tax credit (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 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), 42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4)).

The maximum amount of APTC that can be approved equals:

1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through the 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 2015 is set by federal law at 2.1% to 9.56% of annual household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37).

In an analysis of APTC eligibility, the determination is based on the FPL "for the benefit year for which coverage is requested (45 CFR § 155.305(f)(1)(i)). On the date of your application, that was the 2014 FPL, which is \$15,730.00 for a two-person household (78 Fed. Reg. 5182, 5183).

For annual household income in the range of at least 150% FPL but less than 200% FPL, the expected contribution is between 4.02% and 6.34% of the household income (26 CFR § 1.36B-3(g)(2)).

Cost-Sharing Reductions:

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan through the Marketplace, (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 plan year coverage is requested, and (4) is enrolled in a silver-level qualified health plan (45 CFR § 155.305(g)(1)).

Legal Analysis

Currently at issue are the questions of (1) whether the Marketplace correctly found you not eligible for Medicaid effective January 1, 2015, and based on such finding, (2) whether the Marketplace correctly found you eligible to receive up to \$207.00 monthly of advance premium tax credit and eligible for cost-sharing reductions as of December 6, 2014?

The effective date an individual's Medicaid coverage is on the first day of the month that an individual is determined eligible for Medicaid.

Generally, once adults are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage even if the adult loses Medicaid eligibility because of any changes or updates they make to their Marketplace account.

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 twelve-month period is based on the start date of the original Medicaid eligibility determination.

On January 21, 2014, the Marketplace received your application for health insurance. The Marketplace prepared a preliminary eligibility determination stating that you are eligible to receive Medicaid. On February 20, 2014, the Marketplace issued an eligibility determination stating that you are Medicaid eligible with a start date effective January 1, 2014. The Marketplace also issued a notice stating that your insurance coverage through Medicaid will begin January 1, 2014, and enrollment with CDPHP will begin March 1, 2014.

You were found eligible for Medicaid with a start date effective January 1, 2014; the Marketplace should have continued your Medicaid coverage until December 31, 2014. Therefore, the Marketplace properly found you not eligible for Medicaid effective January 1, 2015.

In your December 5, 2014 application and hearing testimony you attested to an expected yearly income in 2015 of \$28,073.50, and the eligibility determination relied upon that information.

According to the record, you plan on filing a U.S. Income Tax Return with the tax status of Head of Household (with qualifying individual) and will claim one dependent on your 2015 federal income tax return. Therefore, you have a two-person household.

You reside in Albany County, where the second lowest cost silver plan that is available through the Marketplace for an individual costs \$331.49 per month. An annual household income of \$28,073.50 equals 178.47% of the 2014 federal poverty level (FPL) for a two-person household. At 178.47% of the 2014 FPL, the expected contribution to the cost of the health insurance premium is 5.34% of income, or \$124.93 per month.

The maximum amount of advance premium tax credit (APTC) that can be awarded equals the cost of the second lowest cost silver plan in your county (\$331.49 per month) minus your expected contribution (\$124.93 per month), which equals \$206.56 per month. Therefore, rounding to the nearest dollar, the Marketplace correctly determined your APTC to be \$207.00 per month.

Cost-sharing reductions are available to a person who has an annual expected household income no greater than 250% of the FPL. Since your annual household income is 178.47% of the 2014 FPL, the Marketplace correctly found you eligible for cost-sharing reductions.

Since the December 6, 2014, eligibility determination properly states that you are eligible for an APTC of up to \$207.00 per month, eligible for cost-sharing reductions, and not eligible for Medicaid based on continuous coverage, the

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).

December 6, 2014 Marketplace eligibility determination is correct and is AFFIRMED.

Decision

The December 6, 2014 eligibility determination is AFFIRMED.

Effective Date of this Decision: June 10, 2015

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

You remain eligible to receive up to \$207.00 monthly of advance premium tax credit (APTC) and eligible to receive cost-sharing reductions.

You remain ineligible for Medicaid effective January 1, 2015.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 after the date 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 U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c))

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):

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 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 December 6, 2014, eligibility determination is **AFFIRMED**.

You remain eligible to receive up to \$207.00 monthly of advance premium tax credit (APTC) and eligible to receive cost-sharing reductions.

You remain ineligible for Medicaid effective January 1, 2015.


Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:

██████████
██████████

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 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).