



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

Notice of Decision

Decision Date: September 14, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000003344

[REDACTED]

Dear [REDACTED],

On July 17, 2015, you appeared by telephone at a hearing on your appeal of NY State of Health Marketplace's January 6, 2015 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 notice.

Legal Authority

We are sending you this notice in accordance with Code of 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).

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

Decision

Decision Date: September 14, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP00000000334

[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 eligible to receive an advance premium tax credit of up to \$193.00 per month and eligible for cost-sharing reductions, effective January 1, 2015?

Did the Marketplace properly determine that you were not eligible for Medicaid?

Procedural History

On January 5, 2015, the Marketplace received your application for health insurance.

On January 6, 2015, the Marketplace issued an eligibility determination notice that stated you were eligible to enroll in a qualified health plan (QHP); eligible to receive an APTC of up to \$193.00 per month; and, if you selected a silver-level plan, eligible for CSR. This eligibility was effective February 1, 2015. The notice further stated that your daughter was eligible for coverage under CHP at a reduced premium rate of \$9.00 per month, also beginning February 1, 2015. The notice finally stated that you and your daughter were ineligible for Medicaid.

On May 28, 2015, the Marketplace issued a disenrollment notice confirming that your coverage under the Healthfirst Silver plan ended effective May 31, 2015.

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On June 5, 2015, you contacted the Marketplace's Account Review Unit and requested an appeal of the January 6, 2015 eligibility determination insofar as you were found eligible for an APTC no greater than \$193.00 and ineligible for Medicaid.

On July 17, 2015, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. A Spanish-language interpreter (ID# [REDACTED]) also attended the hearing at your request. 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 2015 taxes with a tax filing status of head of household. You will claim your daughter as a dependent on that tax return.
- 2) You are seeking insurance for only yourself since your daughter was already found eligible for CHP through the Marketplace.
- 3) The application that was submitted on January 5, 2015, you attested to receiving \$640.00 per week from your employer, [REDACTED]. You testified that this was accurate when entered by you on your application, and remains accurate going forward.
- 4) The application that was submitted on January 5, 2015, you attested that your daughter received a total of \$1,386.00 between September 1, 2014 and December 31, 2014 from her employer, [REDACTED]. You testified that this was accurately entered on your application. You further testified that since she is attending school this year, and that you anticipate she would earn no more than \$3,000.00 to \$4,000.00 during 2015.
- 5) Your application states that you will not be taking any deductions on your 2015 tax return.
- 6) Your application states that you live in Suffolk County.
- 7) You enrolled in a Healthfirst silver plan beginning February 1, 2015. You testified that you voluntarily terminated this plan effective May 31, 2015 because the total cost of the co-pays and plan premiums rendered this insurance plan too expensive.

- 8) You testified that even after applying the maximum tax credit of \$193.00 per month, your insurance plan was unaffordable due to your current living expenses.

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

Applicable Law and Regulations

Advance Premium Tax Credit

The advance premium tax credit (APTC) is generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable 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 2015 is set by federal law at 2.01% to 9.56% of 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 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 2014 FPL, which is \$15,730.00 for a two-person household (79 Fed. Reg. 3593, 3593).

For annual household income in the range of at least 200% but less than 250% of the 2014 FPL, the expected contribution is between 6.34% and 8.10% of the

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household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP 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 first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

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 (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 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 2014 FPL, which is \$15,730.00 for a two-person household (79 Fed. Reg. 3593).

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).

Modified Adjusted Gross Income

The Marketplace bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term “modified adjusted gross income” means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

The income of a child is not included within the MAGI-based income of an individual if the child is not required to file a tax return under 26 USC § 6012 (45 CFR § 155.300(a), 42 CFR § 435.603(d)(2)). A child whose gross income is less

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than the federal standard deduction applicable to them is not required to file a U.S. Income Tax return (26 USC § 6012(a)(1)). The 2015 federal standard deduction for a tax dependent with a “single” filing status is \$6,300 (IRS Publication IR-2014-104 (Oct. 30, 2014)).

“Adjusted gross income” means, in the case of an individual taxpayer, gross income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from time savings accounts, and deductions attributable to royalties (26 USC § 62(a)).

Legal Analysis

The first issue is whether the Marketplace properly determined that you were eligible for an APTC of no more than \$193.00 per month.

The application that was submitted on January 5, 2015 listed an annual household income of \$33,280.00, which included only the income you received from your employer (\$640.00 x 52 weeks). Since your daughter’s expected income for 2015 was less than that applicable federal standard deduction, her income was not included in your MAGI-based income.

The eligibility determination relied upon that information.

You are in a two-person household. You expect to file you 2015 income taxes as head of household and will claim your daughter as a dependent on that tax return.

You reside in Suffolk County, where the second lowest cost silver plan available for an individual through the Marketplace costs \$379.93 per month.

An annual income of \$33,280.00 is 211.57% of the 2014 FPL for a two-person household. At 211.57% of the FPL, the expected contribution to the cost of the health insurance premium is 6.75% of income, or \$187.12 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through the Marketplace for an individual in your county (\$379.93 per month) minus your expected contribution (\$187.12 per month), which equals \$192.81 per month. Therefore, rounding to the nearest dollar, the Marketplace correctly determined you to be eligible for up to 193.00 per month in APTC.

The second issue is whether you were properly found eligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income

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of \$33,280.00 is 211.57% of the applicable FPL, the Marketplace correctly found you to be eligible for CSR

The third issue is whether the Marketplace properly determined that you were ineligible for Medicaid.

Medicaid can be provided through the Marketplace to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$15,730.00 for a two-person household. Since \$33,280.00 is 211.57% of the 2014 FPL, the Marketplace properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

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 138% of the FPL, which is \$1,808.95 per month. In the application that was submitted on January 5, 2015, you attested to receiving \$640.00 per week from your employer. You testified that this was accurate when entered by you on your application, and remains accurate going forward. Since your income was \$2,560.00 for January 2015, you did not qualify for Medicaid on the basis of monthly income when you submitted your initial application.

Since the January 6, 2015 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$193.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The January 6, 2015 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 14, 2015

How this Decision Affects Your Eligibility

You remain eligible for up to \$193.00 in APTC.

You remain eligible for CSR.

You are ineligible for Medicaid.

If you seek to reenroll in your plan during the 2015 plan year, you will need to qualify for a special enrollment period.

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):

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

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The January 6, 2015 eligibility determination notice is AFFIRMED.

You remain eligible for up to \$193.00 in APTC.

You remain eligible for CSR.

You are ineligible for Medicaid.

If you seek to reenroll in your plan during the 2015 plan year, you will need to qualify for a special enrollment period.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

