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

Notice of Decision

Decision Date: April 20, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000004749

[redacted]

Dear [redacted],

On April 15, 2016 you appeared by telephone at a hearing on your appeal of NY State of Health's September 18, 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 45 Code of Federal Regulations (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.

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).

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

Decision

Decision Date: April 20, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000004749

[redacted]

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 and your son were eligible to receive up to $465.00 per month in advance payments of the premium tax credit (APTC), effective November 1, 2015?
>
> Did NY State of Health properly determine that you and your son were eligible for cost-sharing reductions, effective November 1, 2015?
>
> Did NY State of Health properly determine that you and your son were not eligible for Medicaid?

Procedural History

On September 18, 2015 NY State of Health (NYSOH) issued a notice of eligibility determination stating that you and your son were conditionally eligible to receive up to $465.00 per month in APTC and eligible to receive cost-sharing reductions, effective November 1, 2016. The notice further stated that you and your son were not eligible for Medicaid because your household income was over the allowable income limit for that program. The notice also stated that you needed to provide income documents before December 16, 2015 in order to confirm your eligibility.

On September 21, 2015, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you and your son were not eligible for Medicaid.

On December 4, 2015, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you requested an adjournment because you were not prepared to proceed with the hearing. Your adjournment was granted.

On January 29, 2016, your adjourned telephone hearing was scheduled. You did not appear for this hearing and your appeal was dismissed as a Failure to Appear.

On February 23, 2016, you requested to vacate the dismissal of your appeal. This request was granted.

On April 15, 2016, 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) In the application that was submitted on September 17, 2015 you attested to filing your 2015 taxes with a tax filing status of Head of Household. You attested to claiming one dependent on that tax return.

2) You testified that you were unsure if you still claimed your son as a dependent when you filed your 2015 taxes but you do know he had to file his own return.

3) You are seeking insurance for yourself and your son.

4) The application that was submitted on September 17, 2015 listed annual household income of $32,760.00, consisting of income you earn from your employment.

5) You testified that you make $18.00 an hour and that you work 37.5 hours per week.

6) The September 17, 2015 application also listed expected income that your son earns in the amount of $5,577.00.

7) You testified that you were unsure as to what your son's current income situation is since the amount of hours he works has been cut.

8) Your application states that you live in Nassau County.

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 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).

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 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 NYSOH, (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 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 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 2015 FPL, which is $15,930.00 for a two-person household (80 Fed. Reg. 3236, 3237).

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 MAGI as defined in the federal tax code (45 CFR § 155.300(a), 42 CFR § 603(e), *see* 26 USC § 36B(d)(2)(B)).

With regard to eligibility for financial assistance through the Marketplace, a tax filer's household income includes the MAGI of all the individuals in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.36B-1(e)(1), 42 CFR § 435.603(d)(1)). The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

A person is not required to file a tax return if their gross income is less than the sum of the exemption amount plus the basic standard deduction allowable for that person (26 USC § 6012(1)(A)). For the 2015 year, a dependent who had

yearly gross earned income greater than $6,300.00 or gross unearned income greater than $1,050.00 would be required to file a tax return (see IRS Revenue Procedure 2014-61).

Legal Analysis

The first issue is whether NYSOH properly determined that you and your son were eligible for an APTC of up to $465.00 per month.

The application that was submitted on September 17, 2015 listed an annual household income of $32,760.00, consisting of income you earn from your employment. That application also listed expected income that your son earns in the amount of $5,577.00. However, a dependent's income is not included in a household's income for the purposes of determining NYSOH eligibility if the amount of earned income the dependent receives is less than $6,300.00. Therefore, NYSOH properly determined your household's modified adjusted gross income (MAGI) to be $32,760.00 and the eligibility determination relied upon that information.

Based on the information contained in your September 17, 2015 application, you and your son were in a two-person household. You expected to file you 2015 income taxes as Head of Household and claim your son as a dependent on that tax return.

You reside in Nassau County, where the second lowest cost silver plan available for a primary subscriber and one dependent through NYSOH costs $645.88 per month.

An annual income of $32,760.00 is 208.26% of the 2014 FPL for a two-person household. At 208.26% of the FPL, the expected contribution to the cost of the health insurance premium is 6.63% of income, or $181.00 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 a primary subscriber and one dependent in your county ($645.88 per month) minus your expected contribution ($181.00 per month), which equals $464.88 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your son to be eligible for up to $465.00 per month in APTC.

The second issue is whether you and your son 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 of $32,760.00 is 208.26% of the applicable FPL, NYSOH correctly found you and your son to be eligible for cost sharing reductions.

The third issue is whether NYSOH properly determined that you and your son were ineligible for Medicaid.

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 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 $15,930.00 for a two-person household. Since $32,760.00 is 205.65% of the 2015 FPL, NYSOH properly found you and your son to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the September 18, 2015 eligibility determination properly stated that, based on the information you provided, you and your son were eligible for up to $465.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

Please note that due to your original hearing being adjourned and you request to vacate the dismissal of your adjourned hearing, the 2015 subsidy amount that was under appeal is no longer an accurate reflection of your eligibility. Since you were unable to provide reliable testimony as to what your son's current income situation is and whether or not you are able to claim him as a tax dependent in 2016, the Appeals Unit cannot send your case back for a redetermination of your current eligibility. Please update your NYSOH account or contact NYSOH in order to have your eligibility redetermined.

Decision

The September 18, 2015 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: April 20, 2016

How this Decision Affects Your Eligibility

You were not eligible for Medicaid based on the information you provided on your September 17, 2015 application.

Please note that due to your original hearing being adjourned and you request to vacate the dismissal of your adjourned hearing, the 2015 subsidy amount that was under appeal is no longer an accurate reflection of your eligibility. Since you were unable to provide reliable testimony as to what your son's current income situation is and whether or not you are able to claim him as a tax dependent in 2016, the Appeals Unit cannot send your case back for a redetermination of your

current eligibility. Please update your NYSOH account or contact NYSOH in order to have your eligibility redetermined.

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 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 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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The September 18, 2015 eligibility determination notice is AFFIRMED.

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 were not eligible for Medicaid based on the information you provided on your September 17, 2015 application.

Please update your NYSOH account or contact NYSOH in order to have your eligibility redetermined.

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:

[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).