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

Notice of Decision

Decision Date: April 27, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000005329

[redacted]

Dear [redacted],

On January 27, 2016, [redacted], acting as your Authorized Representative, appeared by telephone at a hearing on your appeal of NY State of Health's November 25, 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 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 27, 2016

NY State of Health Account ID: [redacted]
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[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 not eligible for financial assistance, effective January 1, 2016?

Procedural History

NYSOH received a financial assistance application for health insurance on November 24, 2015. Based on this application, that same day NYSOH prepared a preliminary eligibility determination stating that you were not eligible for financial assistance, effective January 1, 2016.

Also on November 24, 2015, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were found ineligible for financial assistance.

On November 25, 2015, NYSOH issued an eligibility determination notice based on the November 24, 2015 application, stating that you were eligible to enroll in a health plan through NYSOH only at full cost. It also stated that you were not eligible to receive advance payments of the premium tax credit (APTC) because your "ESI waiting period is over" and not eligible for CSR because you were not eligible for an APTC. Finally, the notice stated that you were not eligible for Medicaid because the household income you provided of $20,020.00 was over the allowable income limit for that program. This eligibility determination was effective January 1, 2016.

On January 27, 2016, [redacted], acting as your Authorized Representative, had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your insurance broker, [redacted] of MG Benefits Consulting Group, LLC, also attended the hearing as your witness. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: (1) all earnings statements issued to you during month of November 2015, (2) the last four earnings statements issued to you during January 2016, (3) or other reasonably acceptable documentation confirming your gross earnings during November 2015 and January 2016. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier.

On February 1, 2016, your Authorized Representative provided eight earnings statements issued to you by [redacted], Inc. between November 5, 2015 and January 28, 2016.

Accordingly, the record was closed on February 1, 2016.

Findings of Fact

A review of the record support the following findings of fact:

1) You are single and have no children.

2) Your application reflects that you expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.

3) You are seeking insurance only for yourself.

4) The application that was submitted on November 24, 2015 listed an annual household income of $20,020.00, which consists solely of $385.00 per week you anticipate receiving from your employer, [redacted], [redacted]

5) Your application reflects, and your Authorized Representative stated, that you are paid on a weekly basis.

6) The application that was submitted on November 24, 2015 reflects that beginning November 24, 2015, you are were either eligible for or enrolled in an employer-sponsored health plan at a weekly premium of $36.56.

7) On February 1, 2016, your Authorized Representative provided eight earnings statements reflecting that you received from [redacted], [redacted]: (1) $385.00 on November 5, 2015, (2) $385.00 on November 12,

2015, (3) $423.00 on November 19, 2015, (4) $385.00 on November 26, 2015, (5) 308.00 on December 3, 2015, (6) $399.00 on January 7, 2016, (7) $455.00 on January 14, 2016, (8) $273.00 on January 21, 2016, and (9) $455.00 on January 28, 2016.

8) The earnings statements your Authorized Representative provided to NYSOH reflect that $36.56 per week began to be deducted from your paycheck for enrollment in your employer-sponsored health plan beginning January 14, 2016.

9) Your application states that you will not be taking any deductions on your 2016 tax return.

10) You live in Westchester County, New York.

11) Your Authorized Representative stated that you were seeking financial assistance through NYSOH in order to select a plan, since the plan available through your employer is cost-prohibitive.

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

Advance payments of the premium tax credit (APTC) are 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 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 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)).

To be eligible for an APTC, a taxpayer must meet the eligibility requirements to enroll in a qualified health plan and not be eligible for minimum essential coverage, except for coverage in the individual market (45 CFR § 155.305(f); 26 CFR § 1.36B-2).

Minimum Essential Coverage

Generally, an individual who may enroll in an eligible employer-sponsored plan and an individual who may enroll in the plan because of a relationship to the employee are eligible for what is considered minimum essential coverage under

the plan only if the plan is affordable and provides minimum value (*see* 26 CFR § 1.36B-2(c)(3)(i)).

"Minimum essential coverage" is defined in section 5000A(f) of the Internal Revenue Code and the regulations issued under that section. As described in that section, eligible employer-sponsored plans, including COBRA continuation coverage, are considered minimum essential coverage (26 CFR § 1.36B-2(c)(1) and (3)).

An eligible employer-sponsored plan is "affordable" if the portion of the annual premium that the employee pays for his or her own insurance does not exceed 9.56% of the employee's household income (26 USC § 36B(b)(3)(A), 26 CFR 1.36B-2T(c)(3)(v)(C), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37).

Cost-Sharing Reductions

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan through NYSOH, (2) meets the requirements to receive advanced premium tax credits, (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)).

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)), 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 2015 FPL, which is $11,770.00 for a one-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).

Legal Analysis

The issue under review is whether NYSOH properly determined you to be ineligible for financial assistance, effective January 1, 2016.

The application that was submitted on November 24, 2015 listed an annual household income of $20,020.00. It also included an attestation that you had been enrolled in an employer-sponsored health plan at a weekly premium rate of $36.56.

The eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2016 income taxes as single and will claim no dependents on that tax return.

According to the November 24, 2015 application, and your supporting documentation, you were enrolled in employer-sponsored insurance.

Generally, employer-sponsored plans provide minimum essential coverage and an employee who is enrolled in such a plan is not eligible for an advance premium tax credit (APTC) through NYSOH.

In your application, you attested to an expected yearly income of $20,020.00 and stated that you have insurance coverage through your employer. Generally, employer-sponsored insurance is considered minimum essential coverage. However, the plan must be affordable and provide minimum value. In this case, a plan would be deemed affordable if your premium costs no more than 9.56% of $20,020.00, which is $1,913.91 per year, or $36.81 per week.

Based on the information contained in your application, your weekly premium is $36.56, which is $1,901.12 per year and approximately 9.50% of your household income. Since the cost of your plan is less than 9.56% of your household income, it is affordable. There was no contention made, or evidence offered, that the plan did not provide you minimum value. Therefore, your employer-sponsored plan must be considered minimum essential coverage.

Since you are currently enrolled in a plan that provide you minimum essential coverage, you are not eligible for APTC.

To be eligible for cost-sharing reductions (CSR), an individual must meet the requirements to receive an APTC. Since NYSOH properly determined that you were not eligible to receive an APTC, NYSOH correctly determined that you were also not eligible for CSR.

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 (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 $11,770.00 for a one-person household. Since $20,020.00 is 170.09% of the 2015 FPL, NYSOH properly found you to be not eligible 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.

On February 1, 2016, at the direction of the Hearing Officer, your Authorized Representative provided several earnings statements issued to you that reflects that you received $1,578.00 during November 2015, the month of your application.

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 $1,354.00 per month. Since the documentation your Authorized Representative provided shows that you earned $1,578.00 during November 2015, you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the November 25, 2015 eligibility determination notice properly stated that, based on the information you provided, you were not eligible for APTC, not eligible for CSR, and not eligible for Medicaid, it is correct and is AFFIRMED.

Decision

The November 25, 2015 eligibility determination, and the November 24, 2015 preliminary eligibility determination on which it is based, are AFFIRMED.

Effective Date of this Decision: April 27, 2016

How this Decision Affects Your Eligibility

You remain ineligible for financial assistance.

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.

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 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 November 25, 2015 eligibility determination, and the November 24, 2015 preliminary eligibility determination on which it is based, are AFFIRMED.

You remain ineligible for financial assistance.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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).