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

Notice of Decision

Decision Date: June 1, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000006249

[redacted]

Dear [redacted],

On May 25, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's December 31, 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 NY State of Health 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).

This page intentionally left blank.

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

Decision

Decision Date: June 1, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000006249

[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 were conditionally eligible to receive $0.00 per month in advance payments of the premium tax credit, effective February 1, 2016?
>
> Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On October 8, 2015, NY State of Health (NYSOH) received your completed application for health insurance.

On October 9, 2015, NYSOH issued an eligibility determination notice based on the information contained in the October 8, 2015 application, stating that you were conditionally eligible for Medicaid, pending submission of documentation regarding your citizenship status. This eligibility was effective October 1, 2015.

Also on October 9, 2015, NYSOH issued an enrollment confirmation notice, confirming your enrollment in a Medicaid Managed Care (MMC) plan, effective November 1, 2015.

On December 30, 2015, you updated your NYSOH account, including your income information.

On December 31, 2015, NYSOH issued an eligibility redetermination notice, based on the information contained in your December 30, 2015 application, stating that you were conditionally eligible for $0.00 in advance payments of the premium tax credit (APTC), pending submission of documentation regarding your citizenship status. This eligibility was effective February 1, 2016.

This same notice stated that you were not eligible for cost-sharing reductions or Medicaid because your household income of $52,936.01 was over the allowable income limit for these programs.

Also on December 31, 2015, NYSOH issued a disenrollment notice stating that your coverage in your MMC plan would end effective January 31, 2016 because you were no longer eligible to remain enrolled in your current health insurance.

On January 15, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the December 31, 2015 eligibility determination as it related to your eligibility for Medicaid.

On February 6, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective February 1, 2016. This appears to be the result of an "Aid to Continue" request you made when you requested your appeal.

That same day, you were also re-enrolled into your MMC plan, effective March 1, 2016. Again, this seems to be the result of your request for Aid to Continue, pending the outcome of your appeal.

On May 25, 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) You testified that you expect to file your 2016 taxes with a tax filing status of head of household with qualifying individual. You will claim one dependent on that tax return.

2) You filed this appeal on behalf of yourself only.

3) The application that was submitted on December 30, 2015 listed annual household income of $52,936.01, consisting of income you earn from employment. You testified that this amount was correct.

4) You testified that, when you originally applied for insurance in October 2015, you were only working part time. You testified that you began working full time toward the end of October 2015, and are still working full time.

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

6) You testified that you do not have any reason to expect that your income will increase or decrease this year.

7) The record reflects that you were found conditionally eligible for Medicaid in October 2015, and that you were asked to submit documentation of your citizenship status by January 6, 2016.

8) You testified that you faxed a copy of your passport to NYSOH in October 2015, but that you do not have any record or confirmation that the fax was sent, as you did it from a business.

9) The record does not contain a copy of your passport.

10) You testified that you believed you would receive Medicaid coverage for a year, once you started receiving Medicaid in October 2015, regardless of any change in your income.

11) Your application states that you live in New York County.

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)).

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 2016 is set by federal law at 2.03% to 9.66% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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

For annual household income in the range of at least 300% but less than 400% of the 2015 FPL, the expected contribution is 9.66 % of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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).

<u>Cost-Sharing Reductions</u>

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 $15,930.00for a two-person household (80 Fed. Reg. 3236, 3237).

Most adults determined eligible for Medicaid are guaranteed twelve 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 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 (N.Y. Soc. Serv. Law § 366(4)(c)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of $0.00 per month, effective February 1, 2016.

The application that was submitted on December 30, 2015 listed an annual household income of $52,936.01 and the eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2016 income taxes as head of household with qualifying individual, and will claim one dependent on that tax return.

You reside in New York County, where the second lowest cost silver plan available for an individual subscriber through NYSOH costs $368.26 per month.

An annual income of $52,936.01 is 332.30% of the 2015 FPL for a two-person household. At 332.30% of the FPL, the expected contribution to the cost of the health insurance premium is 9.66% of income, or $426.13 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 subscriber in your county ($368.26 per month) minus your expected contribution ($426.13 per month), which equals **negative** $57.87 per month. Therefore, since your expected contribution is greater than the cost of the second lowest cost silver plan available in New York County for an individual subscriber, NYSOH correctly determined you to be eligible for $0.00 in APTC.

The second issue under review is whether you were properly found not 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 $52,936.01 is 332.30% of the applicable FPL, NYSOH correctly found you to be not eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you were not eligible 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 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 $15,930.00 for a two-person household. Since $52,936.01 is 332.30% 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.

You testified that you believed you would remain eligible for Medicaid for one year, regardless of any change in your income, after you were found conditionally eligible for Medicaid coverage in October 2015.

Most adults determined eligible for Medicaid are guaranteed twelve months of Medicaid coverage even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. However, the October 9, 2015 eligibility determination found you only conditionally eligible for Medicaid, meaning that your eligibility was contingent on your compliance with NYSOH's request for documentation of your citizenship status. While you testified that you faxed a copy of your passport, you were unable to provide proof that you faxed this document, and your NYSOH account does not contain a copy of your passport.

Since NYSOH did not receive the requested citizenship documentation, when you updated your account on December 30, 2015, your eligibility for Medicaid at

that point was still conditional. Therefore, you were not entitled to the twelve months of continuous coverage that other individuals determined eligible for Medicaid receive, and you were properly determined to be conditionally eligible to receive APTC, effective February 1, 2016.

Since the December 31, 2015 eligibility determination properly stated that, based on the information you provided, you were eligible for $0.00 per month in APTC, not eligible for cost-sharing reductions, and not eligible for Medicaid, it is correct and is AFFIRMED.

Decision

The December 31, 2015 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: June 1, 2016

How this Decision Affects Your Eligibility

You remain eligible for $0.00 in APTC.

You are not eligible for cost-sharing reductions.

You are not eligible for Medicaid.

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 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 December 31, 2015 eligibility determination notice is AFFIRMED.

You remain eligible for $0.00 in APTC.

You are not eligible for cost-sharing reductions.

You are not eligible for Medicaid.

Legal Authority

We are sending you this notice 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).