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

Notice of Decision

Decision Date: June 28, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000006541

[redacted]

Dear [redacted],

On June 8, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's January 12, 2016 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).

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Decision

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NY State of Health Account ID: [redacted]
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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 up to $254.00 per month in advance payments of the premium tax credit, effective February 1, 2016?
>
> Did NY State of Health properly determine that you were conditionally eligible for cost-sharing reductions, effective February 1, 2016?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid as of your January 12, 2016 application?

Procedural History

On January 11, 2016, NY State of Health (NYSOH) received your updated application for health insurance.

On January 12, 2016, NYSOH issued an eligibility determination notice, based on the information contained in the January 11, 2016 application, stating that you were conditionally eligible to receive up to $254.00 in advance payments of the premium tax credit (APTC), and conditionally eligible to receive cost-sharing reductions (CSR), effective February 1, 2016.

On January 27, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the eligibility determination, insofar as you wanted to be eligible for a higher level of financial assistance.

On June 8, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open at the end of the hearing for fifteen days to give you time to submit documentation of your income for the month of February. No documentation was submitted to the Appeals Unit nor was any documentation uploaded to your NYSOH account by the close of the fifteenth day (June 23, 2016). The record is now closed.

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 single. You will claim no dependents on that tax return.

2) You are seeking insurance beginning February 1, 2016.

3) The application that was submitted on January 11, 2016 listed annual household income of $24,005.84, consisting of income earned from employment. You testified that this amount was correct.

4) You testified that your income varies some, and that you are now working more days than you were in February 2016. You testified that you expect your income to increase in 2016.

5) You testified that you are starting a new job in two weeks, and that you will then have health insurance through your employer.

6) You testified that you were paid weekly in the month of February. You testified that you were not working as much during February, as you were only on the schedule for two or three days a week.

7) You testified to the following gross pay received in the month of February 2016:

    a. February 2 - $388.52
    b. February 9 - $511.40
    c. February 16 - $324.50
    d. February 23 - $495.00

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

9) Your application states that you live in Suffolk County.

10) You testified that you do not have any outstanding medical bills because you have paid for any medical expenses out of pocket since February 1, 2016.

11) You testified that you are looking to be eligible for more affordable coverage because you have a lot of expenses and cannot afford the premiums for your qualified health plan (QHP).

12) The Hearing Officer directed you to submit documentation of your income for the month of February by June 23, 2016. No documentation was submitted.

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 $11,770.00 for a one-person household (80 Federal Register 3236, 3237).

For annual household income in the range of at least 200% but less than 250% of the 2015 FPL, the expected contribution is between 6.41% and 8.18% 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).

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), 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). The 2016 FPL is $11,880.00 for a one-person household. (81 Fed. Reg. 4036).

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 first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $254.00 per month, effective February 1, 2016.

The application that was submitted on January 11, 2016 listed an annual household income of $24,005.84 and 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.

You reside in Suffolk County, where the second lowest cost silver plan available for an individual through NYSOH costs $385.23 per month.

An annual income of $24,005.84 is 203.96% of the 2015 FPL for a one-person household. At 203.96% of the FPL, the expected contribution to the cost of the health insurance premium is 6.55% of income, or $131.03 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 in your county ($385.23 per month) minus your expected contribution ($131.03 per month), which equals $254.20 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $254.00 per month in APTC.

The second issue under review 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 of $24,005.84 is 203.96% of the applicable FPL, NYSOH correctly found you to be 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 $11,770.00 for a one-person household. Since $24,005.84 is 203.96% of the 2015 FPL, NYSOH properly found you to be ineligible 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.

You testified to receiving four paychecks with gross income amounts of $388.52, $511.40, $324.50, and $495.00 in the month of February 2016, which is the month you are looking for your eligibility to begin.

You were directed to submit documentation of your monthly income for February 2016, but no documentation was submitted. However, the amounts that you testified to add up to $1719.42.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the 2016 FPL, which is $990.00 per month. Since $1719.42 is 173.68% of the 2016 monthly FPL, you do not qualify for Medicaid on the basis of monthly income as of February 1, 2016, based on the income you attested to at the hearing.

Therefore, as the January 12, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $254.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

If your income has changed since your application, you can update your NYSOH account in order to have your eligibility redetermined.

Decision

The January 12, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: June 28, 2016

How this Decision Affects Your Eligibility

This decision has no impact on your current eligibility.

You were eligible for APTC of up to $254.00 per month, effective February 1, 2016.

You were eligible for CSR, effective February 1, 2016.

You were not eligible for Medicaid as of February 1, 2016 on either an annual income or monthly income basis.

If your income has changed since your application, you may update your NYSOH account and submit income documentation so that your eligibility can be 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 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 January 12, 2016 eligibility determination notice is AFFIRMED.

This decision has no impact on your current eligibility.

You were eligible for APTC of up to $254.00 per month, effective February 1, 2016.

You were eligible for CSR, effective February 1, 2016.

You were not eligible for Medicaid as of February 1, 2016 on either an annual income or monthly income basis.

If your income has changed since your application, you may update your NYSOH account and submit income documentation so that your eligibility can be redetermined.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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