



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

Notice of Decision

Decision Date: August 16, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000006636

[REDACTED]

Dear [REDACTED]

On July 28, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's January 29, 2016 eligibility redetermination as it relates to you.

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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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 newly eligible to receive up to \$153.00 per month in advance payments of the premium tax credit, effective March 1, 2016?

Did NY State of Health properly determine that you were newly eligible for cost-sharing reductions?

Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On January 12, 2016, NY State of Health (NYSOH) issued a renewal notice that informed you to update the information on your NYSOH account by February 15, 2016 so your eligibility for financial assistance could be redetermined for the upcoming policy year.

On January 29, 2016, NYSOH received your completed application for health insurance upon renewal. That day, a preliminary eligibility redetermination was prepared with regard to that application finding you newly eligible to receive up to \$153.00 per month in advance payments of the premium tax credit (APTC) and newly eligible for cost sharing reductions, effective March 1, 2016.

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Also on January 29, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not eligible for Medicaid any longer.

On January 30, 2016, NYSOH issued an eligibility redetermination notice that was consistent with the January 29, 2016 preliminary redetermination.

Also on January 30, 2016, NYSOH issued a disenrollment notice that stated your coverage in your Medicaid Managed Care (MMC) plan would end effective February 29, 2016.

On February 18, 2016, NYSOH granted your request for aid to continue for you and your child in your MMC plan during the appeals process.

On February 19, 2016, NYSOH issued an eligibility redetermination notice that stated you and your child were eligible for Medicaid, effective March 1, 2016, on an aid to continue basis pending the outcome of your appeal.

The February 19, 2016 enrollment notice confirmed that both you and your child had been placed back in your MMC plan, effective March 1, 2016.

On July 13, 2016 and since your hearing was rescheduled for July 28, 2016, NYSOH issued notices of eligibility redetermination and enrollment that extended your and your child's coverage in your MMC plan on an aid to continue basis as of August 1, 2016 through September 30, 2016.

On July 28, 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 for up to fifteen days to allow you to submit supporting documentation.

On August 9, 2016, as proof of household income, you uploaded your and your spouse's Social Security Award letters and your child's Social Security Benefits Award letter (see, Documents [REDACTED]; [REDACTED]; and [REDACTED]). The record remained open until August 12, 2016, for you to submit your and your spouse's 2015 federal tax return.

As of August 12, 2016, a copy of your 2015 federal tax return had not been uploaded to your NYSOH account nor was it received by the Appeals Unit as had been directed by the Hearing Officer. Therefore, the record was closed that same day and this decision is issued based on the record as developed as of August 9, 2016.

Findings of Fact

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

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- 1) You testified that you expect to file your 2016 taxes with a tax filing status of married filing jointly. You will claim your one minor child as a dependent on that tax return.
- 2) You are seeking insurance for yourself only.
- 3) You testified that your child's eligibility for Child Health Plus is not at issue and you can afford to pay \$9.00 per month once the appeal is resolved; and your spouse is certified disabled so he has health insurance coverage through Medicare.
- 4) The application that was submitted on January 29, 2016 listed annual household income of \$41,748.00, consisting of \$696.00 (\$58.00 x 12 months) in Title II income that you receive and \$41,052.00 that your spouse receives, including Title II income of \$24,948.00 (\$2,079.00 x 12 months) and retirement earnings of \$16,104.00. You testified that these amounts were correct. These amounts equal \$41,748.00 in annual income.
- 5) Your application states that you will not be taking any deductions on your 2016 tax return.
- 6) Your application states that you and your family reside in Suffolk County, New York.
- 7) You testified that you have a recurring medical condition that prevents you from working a regular job and that the current health plan coverage being offered through NYSOH requires you to pay a \$3,000.00 annual deductible, which you cannot afford in addition to a monthly insurance premium for yourself.
- 8) You testified that you want your eligibility to be reconsidered for financial assistance that is affordable to you.

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

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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 \$20,090.00 for a three-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 in 2016 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 2016 FPL, which is \$20,160.00 for a three-person household (81 Fed. Reg. 4036).

People who receive or are eligible for Medicaid are not eligible for APTC since they have, or will soon have, active coverage in the system. They will be enrolled or remain in their Medicaid plan for 12 months, with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, failing to provide a valid Social Security number, or having third party health insurance (N.Y. Soc. Serv. Law § 366(4)(c)).

Affordability Exemption

Under some circumstances, a person may receive an exemption from paying a penalty for not purchasing health insurance coverage. Such an exemption may be granted if that person can show that he or she experienced a financial hardship or has domestic circumstances that (1) caused an unexpected increase in essential expenses that prevented that person from obtaining health coverage under a QHP; (2) would have caused the person to experience serious deprivation of food, shelter, clothing, or other necessities, as a result of the expense of purchasing health coverage under a QHP; or (3) prevented that person from obtaining coverage under a QHP (45 CFR § 155.605(a), (g)).

NYSOH has deferred to the U.S. Department of Health and Human Services (HHS) on the matter of hardship exemptions (see 45 CFR § 155.505(c)).

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Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible to receive APTC of up to \$153.00 per month.

The application that was submitted on January 29, 2016 listed an annual household income of \$41,748.00 and the eligibility determination relied upon that information.

You are in a three person household for purposes of this analysis. This is because you expect to file your 2016 income taxes as married filing jointly and will claim your one child as a dependent on that tax return.

You reside in Suffolk County, where the second lowest cost silver plan available for an individual through NYSOH costs \$385.22 per month.

An annual income of \$41,748.00 is 207.8% of the 2015 FPL for a three-person household. At 207.8% of the FPL, your expected contribution to the cost of the health insurance premium is 6.69% of income, or \$232.75 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 (\$385.22 per month) minus your expected contribution (\$232.75 per month), which equals \$152.47 per month. Therefore, rounding up to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$153.00 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 of \$41,748.00 is 207.8% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue 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 \$20,160.00 for a three-person household. Since \$41,748.00 is 207.08% of the 2016 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the January 30, 2016 eligibility redetermination notice properly stated that, based on the information you provided, you were eligible for up to \$153.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

If you wish to be considered for a hardship exemption, which would exempt you from paying a penalty for not having health insurance during 2016, you can check the Federal Marketplace website (www.healthcare.gov) for direction.

Decision

The January 30, 2016 eligibility redetermination notice is AFFIRMED.

Effective Date of this Decision: August 16, 2016

How this Decision Affects Your Eligibility

You remain eligible for up to \$153.00 per month in APTC.

You remain eligible for cost-sharing reductions.

You are ineligible 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

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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:
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Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The January 30, 2016 eligibility redetermination notice is **AFFIRMED**.

You remain eligible for up to \$153.00 per month in APTC.

You remain eligible for cost-sharing reductions.

You are ineligible for Medicaid.

If you wish to be considered for a hardship exemption, which would exempt you from paying a penalty for not having health insurance during 2016, you can check the Federal Marketplace website (www.healthcare.gov) for direction.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

