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

Notice of Decision

Decision Date: August 08, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000007143

[redacted]

Dear [redacted],

On July 18, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's February 10, 2016 eligibility determination notice.

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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: August 08, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000007143

[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 newly eligible to receive up to $202.00 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, effective March 1, 2016?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On January 8, 2015, a renewal notice was issued stating it was time to renew your health coverage. You were found to be eligible for Medicaid effective March 1, 2015. This was because your household income was between $0.00 and $16,105.00. You were subsequently re-enrolled in your health plan for another year.

On January 14, 2016, a renewal notice was issued stating based on information from federal and state data sources, a decision could not be made about whether or not you qualified for financial assistance. You were asked to update the information in your account by February 15, 2016 or risk losing the financial assistance you were currently receiving.

On February 9, 2016, NY State of Health (NYSOH) received your completed application for health insurance.

On February 10, 2016, an eligibility determination notice was issued finding you newly eligible to receive advance premium tax credits up to $202.00 per month, as well as newly eligible to receive cost sharing reductions. You were further found ineligible for Medicaid. This determination was based on your attested household income of $28,200.00, effective March 1, 2016.

Also on February 10, 2016, a disenrollment notice was issued terminating your coverage with your Medicaid Managed Care plan effective February 29, 2016.

On February 17, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the February 10, 2016 eligibility determination in regards to the level of financial assistance you were determined eligible to receive. You also requested Aid to Continue.

On March 8, 2016, an eligibility redetermination notice was issued finding you eligible for Medicaid effective March 1, 2016. That same day, you were enrolled in a Medicaid Managed Care plan effective April 1, 2016. These results were based on your request for Aid to Continue during the length of your appeal.

On July 18, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open 15 days for you to provide income documents for the month of March, 2016 in the form of four weeks of paystubs, or a letter from your employer showing gross wages received that month. Documentation was received as an uploaded document on July 21, 2016 and incorporated into the record as (Appellant's Exhibit 1) See document [redacted]

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 for yourself.

3) You testified you are seeking to be found eligible for a higher amount of financial assistance or to be found eligible for Medicaid.

4) The application that was submitted on February 9, 2016, listed annual household income of $28,200.00, consisting of income you earn from your employment. You testified that this amount was correct.

5) You testified that you believe the average monthly income of $2,350.00 per month seemed high to you.

6) The record supports you included income from three employers on your prior application consisting of $500.00 once every two weeks from [redacted]., $1,000.00 from [redacted], Inc. starting 5/1/15 to 10/15/15, and $100.00 a week from [redacted].

7) You testified that your employment with [redacted] is seasonal only.

8) You testified you were not sure what your gross income was for the month of March 2016.

9) You provided income documentation on July 21, 2016 in the form of a paystub with a pay date of April 1, 2016, in the amount of $1,300.00 for the pay period of 3/10/2016 to 3/28/2016 (Appellant's Exhibit 1) See document [redacted]

10) Your request for Aid to Continue during the length of your appeal which was granted and you were found eligible for Medicaid effective March 1, 2016, and enrolled into a Medicaid Managed Care plan starting April 1, 2016, lasting through the length of your appeal.

11) Your application states that you live in Suffolk 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).

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 2016 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).

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 $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 is whether NYSOH properly determined that you were eligible for an advance premium tax credit (APTC) of up to $202.00 per month.

The application that was submitted on February 9, 2016, listed an annual household income of $28,200.00 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 $28,200.00 is 239.59% of the 2016 federal poverty level (FPL) for a one-person household. At 239.59% of the FPL, the expected contribution to the cost of the health insurance premium is 7.81% of income, or $183.55 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 ($183.55 per month), which equals $201.68 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $202.00 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 $28,200.00 is 239.59% 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 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 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 $16,395.00 for a one-person household. Since $28,200.00 is 237.37% 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.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

The record supports you included income from three employers on your application consisting of $500.00 once every two weeks from [redacted], Inc., $1,000.00 from [redacted], Inc. starting 5/1/15 to 10/15/15, and $100.00 a week from [redacted].

You testified that your employment with [redacted] is seasonal only.

The Hearing Officer requested that you provide income documents for the month of March, 2016, in the form of four weeks current paystubs, or letter from your employers showing gross wages received during that month.

You provided income documentation on July 21, 2016, in the form of a paystub with a pay date of April 1, 2016, in the amount of $1,300.00 for the pay period of 3/10/2016 to 3/28/2016 (Appellant's Exhibit 1) See document [redacted]

Since the documentation you provided shows that you earned $1,300.00 in April, 2016 and not the requested month of March, 2016, a determination cannot be made as to whether you would qualify for Medicaid on the basis of monthly income as of the date of your application. Furthermore, no documentation was received from you which included proof of income from your second employer [redacted].

Since the February 10, 2016, eligibility determination properly stated that, based on the information you provided, you were eligible for up to $202.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The February 10, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: August 08, 2016

How this Decision Affects Your Eligibility

You remain eligible for up to $202.00 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 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 February 10, 2016 eligibility determination notice is AFFIRMED.

You remain eligible for up to $202.00 in APTC.

You remain eligible for cost-sharing reductions.

You are ineligible 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).