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

Notice of Decision

Decision Date: October 24, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000007201

[redacted]

Dear [redacted],

On July 28, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's February 16, 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: October 24, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000007201

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you were conditionally eligible to receive up to $180.00 per month in advance payments of the premium tax credit, effective March 1, 2016?
>
> Did NYSOH properly determine that you were conditionally eligible for cost-sharing reductions, effective March 1, 2016?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On February 27, 2015, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid. This eligibly determination was effective January 1, 2015.

On December 17, 2015, NYSOH issued an eligibility determination notice stating that it was time to renew your NY State of Health coverage. The notice also stated that based on the information about you from state and federal data sources obtained as of December 15, 2015, you were found eligible for an advance premium tax credit (APTC) of $0.00 per month; ineligible for cost-sharing reductions (CSR); and, ineligible for Medicaid. This eligibility determination was effective February 1, 2016.

On December 18, 2015, NYSOH received a revised application for health insurance.

On December 19, 2015, NYSOH issued an eligibility redetermination notice based on the information contained in the December 18, 2015 application. The notice stated that you were no longer eligible for Medicaid; however, your Medicaid coverage would continue until January 31, 2016. The notice advised you to update your application between December 17, 2015 and January 16, 2016 so that NYSOH could make a determination about your health insurance.

On January 25, 2016, NYSOH received a revised application for health insurance.

On January 26, 2016, NYSOH issued an eligibility redetermination notice based on the information contained in the January 25, 2016 application. It stated that you were newly eligible to receive an APTC of up to $107.00 per month, effective March 1, 2016. The notice also stated that you were not eligible for CSR or Medicaid at that time.

Also on January 26, 2016, NYSOH issued a disenrollment notice stating that your Medicaid coverage with CDPHP would end effective February 29, 2016.

On February 15, 2016, NYSOH received a revised application for health insurance.

On February 16, 2016, NYSOH issued an eligibility redetermination notice based on the information contained in the February 15, 2016 application. It stated that you were conditionally eligible to receive an APTC of up to $180.00 per month; conditionally eligible to receive CSR, provided you selected a silver-level plan; and, ineligible for Medicaid. Your eligibility for APTC and CSR was conditional pending receipt of documentation to prove your income before May 15, 2016. This eligibility determination was effective March 1, 2016.

Also on February 16, 2016, NYSOH issued a notice of enrollment confirming your selection of a qualified health plan (QHP) and standalone dental plan as of February 15, 2016. The notice stated that your enrollment in each plan would begin effective March 1, 2016.

Also on February 18, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the February 16, 2016 eligibility determination notice insofar as you were not found eligible for Medicaid or, in the alternative, a greater amount APTC to decrease your QHP premium.

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 remained open as the Hearing Officer directed you to provide as additional

evidence to corroborate your testimony: (1) letter from your employer, [redacted], confirming gross income paid to you during February 2016, (2) reasonably acceptable evidence reflecting the gross income received from [redacted] during the month of February 2016, (3) reasonably acceptable evidence reflecting the gross income received from [redacted] during the month of February 2016, (4) a list of deductions expected to be claimed during Feb 2016, and (5) your 2015 tax return. 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 August 4, 2016, you provided to the Appeals Unit through your NYSOH account (1) two earning statements you received from your employer, [redacted], during the month of February 2016 and (2) a copy of your 2015 tax return.

Since these documents were not consistent with those requested by the Hearing Officer, the record was closed on August 12, 2016.

Findings of Fact

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

1) You testified that you are only seeking an appeal with respect to your eligibility through NYSOH.

2) You testified, and the record reflects, that you expect to file your 2016 taxes with a tax filing status of head of household. You will claim your daughter as your sole dependent on that tax return.

3) You are seeking insurance for only for yourself since you daughter had been enrolled in Child Health Plus through NYSOH.

4) The application that was submitted on February 15, 2015 listed annual household income of $35,500.00, consisting of $1,250.00 you earn once every two weeks from your employer, [redacted], and $250.00 per month you receive in "Other Income." You clarified during the hearing that this income was received from your [redacted] work as an independent contractor with [redacted]. You have been actively working for this entity since December of 2015. You testified that these amounts were correct as of the time you submitted your application.

5) You testified that during the month of March 2016, you received a raise from $35,500.00 to $41,000.00. This was reflected as an increase in your bi-weekly paycheck from $1,250.00 to $1,576.92. You further testified that

your employer provided you this raise to assist you in affording health insurance through NYSOH.

6) You testified that in additional to your independent contractor work with [redacted], you are also retained by [redacted] on an independent contractor basis, and that you received $500.00 per month through your PayPal account.

7) Your February 15, 2106 application stated that you will not be taking any deductions on your 2016 tax return. You testified, however, that your loans from school amount to approximately $1,200.00 per month.

8) You testified that your daughter's schooling costs approximately $800.00 per month.

9) You testified that your cost of living expenses, which include rent, credit card debt and other essentials make QHPs available through NYSOH unaffordable without additional financial assistance.

10) At the time of your February 15, 2016 application, you lived in Albany County, New York. You testified that as of June 10, 2016, you and your daughter moved to Saratoga County, New York.

11) On August 4, 2016, you provided a copy of your 2015 tax return, which reflected that you did not claim any student loan interest deductions (line 33), and that you adjusted gross income was $29,589.00 (line 37).

12) On August 4, 2016, you provided two earning statements issued to you by your employer, [redacted], reflecting that you received (1) $1,346.15 on February 11, 2016 and (2) $1,576.92 on February 25, 2016.

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 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).

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 $16,020.00 for a two-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 APTC of up to $180.00 per month.

The application that was submitted on February 15, 2016 listed an annual household income of $35,500.00, consisting of $1,250.00 you earn once every two weeks from your employer, [redacted], and $250.00 per month you receive as an independent contractor of [redacted]. 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 and will claim you daughter as your sole dependent on that tax return.

As of the submission of your application on February 15, 2016, you resided in Albany County, where the second lowest cost silver plan available for an individual through NYSOH costs $393.63 per month.

An annual income of $35,500.00 is 222.85% of the 2015 FPL for a two-person household. At 222.85% of the FPL, the expected contribution to the cost of the health insurance premium is 7.22% of income, or $213.59 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 ($393.63 per month) minus your expected contribution ($213.59 per month), which equals $180.04 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $180.00 per month in APTC.

The second issue is whether you were properly found eligible for CSR.

CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of $35,500.00 is 222.85% of the applicable FPL, NYSOH correctly found you to be eligible for CSR.

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, February 15, 2016, the relevant FPL was $16,020.00 for a two-person household. Since $35,500.00 is 221.60% 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.

At the request of the Hearing Officer, you submitted two earning statements reflecting that during the month of your application, February 2016, you received $1,346.15 and $1,576.92 from [redacted], on February 11, 2016 and February 25, 2016, respectively. However, you did not provide any documentation confirming receipt of income during February 2016 from either [redacted] or [redacted].

While you testified that you are responsible for $1,200.00 per month in student loan payment, the credible evidence of record reflects that you are not claiming, or cannot claim any portion of that amount, as a student loan interest deduction.

Finally, while you claimed that you pay approximately $800.00 per month for you daughter's schooling, these amounts cannot be claimed as a deduction for tuition payments on your 2016 tax return, and do no lower your overall amount of income to determine you eligibility for financial assistance.

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 $1,842.00 per month. Since the documentation you provided is insufficient to determine the precise income you received during February 2016, we are unable to return your case to NYSOH to assess whether you qualify for Medicaid on the basis of monthly income as of the date of your application.

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).

Since the February 16, 2016 eligibility determination notice properly stated that, based on the information you provided, you were conditionally eligible for up to $180.00 per month in APTC, conditionally eligible for CSR, and ineligible for Medicaid, it is correct and is AFFIRMED.

The credible evidence of record, as developed during the hearing, reflects you now anticipate receiving (1) $41,000.00 ($1,576.92 x 26 weeks) from [redacted], (2) $6,000.00 ($500.00 x 12 months) from [redacted] and (3) $3,000.00 ($250.00 x 12 months) from [redacted]. The record also reflects that you now reside in Saratoga County, New York, with your daughter.

Since a revised application was submitted to NYSOH on August 30, 2016 virtually mirroring your new anticipated income for 2016, and your residency in Saratoga County, we decline to return your case to NYSOH to redetermine your eligibility since an eligibility redetermination notice was issued on August 31, 2016 reflecting this result, effective October 1, 2016. This determination found you conditionally eligible for $0.00 of APTC, ineligible for CSR, and ineligible for Medicaid.

Decision

The February 16, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 24, 2016

How this Decision Affects Your Eligibility

As of March 1, 2016, you were properly found eligible for up to $180.00 per month in APTC and, if you select a silver-level plan, eligible for CSR.

However, as of October 1, 2016, you are no longer eligible for ATPC as a result of your increase in anticipated income during 2016.

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.

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 February 16, 2016 eligibility determination notice is AFFIRMED.

As of March 1, 2016, you were properly found eligible for up to $180.00 per month in APTC and, if you select a silver-level plan, eligible for CSR.

However, as of October 1, 2016, you are no longer eligible for ATPC as a result of your increase in anticipated income during 2016.

You are ineligible for Medicaid.

Legal Authority

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).

We are sending you this notice in accordance with 45 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).

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).