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

Notice of Decision

Decision Date: October 4, 2016

NY State of Health Account ID:
Appeal Identification Number: AP000000007575

Dear

On August 22, 2016 you appeared by telephone at a hearing on your appeal of NY State of Health's March 3, 2016 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: October 4, 2016

NY State of Health Account ID:
Appeal Identification Number: AP000000007575

Issues

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

> Did New York State of Health properly determine that you were eligible to receive up to $34.00 monthly of advance premium tax credit as of March 3, 2016?
>
> Did New York State of Health properly determine that you were not eligible for Medicaid as of March 3, 2016?

Procedural History

On February 12, 2016, your New York State of Health (NYSOH) account was updated. NYSOH rendered a preliminary eligibility determination stating that you were eligible for Medicaid. However, additional income documentation was needed within 15 days to confirm your eligibility.

On February 12, 2016, you uploaded documentation to your NYSOH account .

On February 13, 2016, NYSOH issued an eligibility determination notice that, based on your February 12, 2016 updated application, you were conditionally eligible for Medicaid, effective as of February 1, 2016. The notice also stated that additional income documentation was needed to confirm your eligibility and was directed to submit the documentation before February 27, 2016.

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On February 24, 2016, NYSOH issued an eligibility determination notice that you were newly eligible to receive up to $34.00 of advance premium tax credit per month, effective as of April 1, 2016. The notice also stated that you were not eligible for Medicaid because the household income you provided was over the allowable income limit.

On March 2, 2016, your NYSOH account was updated. NYSOH rendered a preliminary eligibility determination that you were eligible to receive up to $34.00 of advance premium tax credit per month, effective as of April 1, 2016.

On March 2, 2016, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as being found not eligible for Medicaid.

On March 3, 2016, NYSOH issued an eligibility determination notice that you were newly eligible to receive up to $34.00 of advance premium tax credit per month, effective as of April 1, 2016. The notice also stated that you were not eligible for Medicaid because the household income you provided was over the allowable income limit.

On August 22, 2016 you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until August 23, 2016 to allow you to submit your two most recent biweekly Earnings Statements to NYSOH Appeals Unit.

On August 23, 2016, you faxed three-pages of documents to NYSOH Appeals Unit. That fax has been marked as "Appellant Exhibit A" and made part of the record. The record is now complete and closed.

Findings of Fact

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

1. According to your NYSOH account and testimony, you are applying for health insurance through NYSOH for yourself.

2. According to your NYSOH account, your marital status is single.

3. According to your NYSOH account, you plan on filing a 2016 federal income tax return with tax status of Head of Household (with qualifying individual), and no dependents were listed in your account.

4. According to your March 2, 2016 NYSOH application, your 2016 expected annual household income is $41,600.00.

5. On February 12, 2016, you uploaded two biweekly Earnings Summaries to your NYSOH account

(a) You were issued $1,600.00 on January 15, 2016
(b) You were issued $1,600.00 on January 29, 2016

6. You testified that you were issued $1,600.00 biweekly from your employer, until June 2016.

7. According to your March 2, 2016 NYSOH application and testimony, you were pregnant with an expected due date of September 30, 2016.

8. You testified that your biweekly income was reduced to $1,475.00 in June 2016.

9. On August 22, 2016, you faxed two biweekly Earnings Statements to NYSOH Appeals Unit:

   (a) You were issued $1,475.74 on July 29, 2016;
   (b) You were issued $1,401.95 on August 12, 2016

   (Appellant Exhibit A p. 2-3).

10. You have been diagnosed with and take five different medications to prevent an attack (Appellant Exhibit A p. 1).

11. You currently reside in Bronx County, NY.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (*see* 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

APTC Household Composition

For purposes of advance premium tax credit (APTC), the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26

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USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

Advance Premium Tax Credit:

The advance premium tax credit is available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the 2015 federal poverty level; (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 qualified health plan; 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 the 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).

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

In an analysis of APTC eligibility, the determination is based on the FPL "for the benefit year for which coverage is requested. (45 CFR § 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 Fed. Reg. 3236, 3237).

Medicaid Household Composition

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid-Pregnant Women

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).

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); New York State Department of Health 13 OHIP/ADM-03).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

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 you eligible for up to $34.00 monthly of APTC as of March 3, 2016.

According to the record, you have a one-person tax household. You expect to file your 2016 federal income tax return with the tax status of Head of Household (with qualifying individual), and there were no dependents listed in your NYSOH account.

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

The March 3, 2016 eligibility determination was based on an annual household income of $41,600.00, which was the amount attested to as your expected annual household income for 2016.

An annual household income of $41,600.00 equals 353.44% of the 2015 FPL for a one-person household. At 353.44% of the FPL, the expected contribution to the cost of the health insurance premium is 9.66% of income, or $334.88 per month.

The maximum amount of APTC that can be awarded equals the cost of the second lowest cost silver plan in your county ($368.26 per month) minus your expected contribution ($334.88 per month), which equals $33.38 per month. Therefore, NYSOH correctly computed your APTC to be $34.00 per month.

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The second issue is whether NYSOH properly determined that you were not eligible for Medicaid as of March 3, 2016.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman but also the number of children she expects to deliver.

On the date of your March 2, 2016 NYSOH application, you attested to being pregnant with one child. Therefore, your household size for determining your eligibility for Medicaid was two as of March 3, 2016.

Medicaid can be provided to a pregnant woman who meets the non-financial criteria and has an income no greater than 223% of the FPL for the applicable family size.

On the date of your application, the relevant FPL was $16,020.00 for a two-person household. Since $41,600.00 is 259.68% of the 2016 FPL, NYSOH properly found you to be not eligible 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.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is $2,978.00 per month for a two-person household. Since the available record shows that you were earning ($1,600.00 X 2) $3,200.00 per month at the time of your March 3, 2016 eligibility determination, you did not qualify for Medicaid.

However, you credibly testified that your biweekly income was reduced to $1,475.00 in June 2016. Furthermore, you submitted two biweekly Earnings Statements to corroborate your testimony, which show that you were issued 1,475.74 on July 29, 2016, and $1,401.95 on August 12, 2016.

The record contains sufficient testimony and documentation to return your case to NYSOH to recalculate your eligibility for financial assistance. Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on two-person household, living in Bronx County with an August 2016 income of ($1,475.00 X 2) $2,950.00.

Decision

The March 3, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on two-person household, living in Bronx County with an August 2016 income of ($1,475.00 X 2) $2,950.00.

Effective Date of this Decision: October 4, 2016

How this Decision Affects Your Eligibility

You remain eligible to receive an advance premium tax credit of up to $34.00 per month.

You remain not eligible for Medicaid.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on two-person household, living in Bronx County with an August 2016 income of ($1,475.00 X 2) $2,950.00.

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 after the date 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 date 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

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- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The March 3, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on two-person household, living in Bronx County with an August 2016 income of ($1,475.00 X 2) $2,950.00.

You remain eligible to receive an advance premium tax credit of up to $34.00 per month.

You remain not eligible for Medicaid.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:

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