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

Notice of Decision

Decision Date: September 5, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000007582

[redacted]

Dear [redacted],

On August 31, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's March 2, 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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DEPARTMENT OF HEALTH
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Decision Date: September 5, 2016

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 eligible to receive up to $243.00 per month in advance payments of the premium tax credit, effective April 1, 2016?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

According to your NY State of Health (NYSOH) account, you were enrolled in a Medicaid Managed Care plan with coverage through February 29, 2016.

On January 13, 2016, (NYSOH) issued a renewal notice stating that, 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.

No updates to your account were made by February 15, 2016.

On February 17, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective March 1, 2016, because you did not qualify for Medicaid, Child Health Plus, the Essential Plan or to receive advance premium tax credits to help pay for the cost of your insurance. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame. As a result you no longer qualified to receive financial assistance to help pay for your health coverage.

On February 18, 2016, NYSOH issued a disenrollment notice stating that your Medicaid Managed Care plan coverage would end effective February 29, 2016.

On March 2, 2016, NYSOH received your completed application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, finding you eligible to enroll in a qualified health care plan, that you were eligible to receive advance premium tax credits up to $243.00 per month, as well as newly eligible to receive cost sharing reductions, effective April 1, 2016. You were further found ineligible for Medicaid. This determination was based on your attested household income of $25,000.00.

Also on March 2, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the level of financial assistance you were determined eligible to receive. You also requested Aid to Continue.

On March 3, 2016, NYSOH issued an eligibility redetermination with findings that were consistent with the March 2, 2016 preliminary determination.

On March 10, 2016, NYSOH issued an enrollment confirmation notice based upon your March 9, 2016 silver-level qualified health plan (QHP) selection with a plan enrollment start date of April 1, 2016.

On March 19, 2016, NYSOH granted your request for Aid to Continue in your Medicaid Managed Care plan during the appeals process.

Also on March 19, 2016 NYSOH issued a cancellation notice stating that your silver level QHP would end effective April 1, 2016.

Also on March 19, 2016, NYSOH issued an enrollment confirmation notice stating you were enrolled in a Medicaid Managed Care plan under Aid to Continue with a plan enrollment start date of March 1, 2016.

On August 31, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

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) The application that was submitted on March 2, 2016 listed annual household income of $25,000.00, consisting of wages you earn from your employment. You testified that this amount is accurate.

4) You testified that you earn approximately $22.00 an hour and you are paid every week. Your weekly income varies a little based on the time of year.

5) The record reflects that you average $2,083.33 in monthly income.

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

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

8) Your application states and you confirmed that you live in Nassau 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, 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 2016 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).

<u>Cost-Sharing Reductions</u>

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 (80 Fed. Reg. 3236, 3237).

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 $243.00 per month.

The application that was submitted on March 2, 2016 listed an annual household income of $25,000.00 and the eligibility determination relied upon that information.

You are in a one-person household. This is because you expect to file your 2016 income taxes as single and will claim no dependents on that tax return.

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

An annual income of $25,000.00 is 212.40% of the 2016 FPL for a one-person household. At 212.40% of the FPL, the expected contribution to the cost of the health insurance premium is 6.85% of income, or $142.69 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 ($142.69 per month), which equals $242.54 per month. Therefore, rounding to the nearest

dollar, NYSOH correctly determined you to be eligible for up to $243.00 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 $25,000.00 is 212.40% 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 $11,880.00 for a one-person household. Since $25,000.00 is 210.44% 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 March 3, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $243.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The March 3, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 5, 2016

How this Decision Affects Your Eligibility

You remain eligible for up to $243.00 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 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 March 3, 2016 eligibility determination notice is AFFIRMED.

You remain eligible for up to $243.00 per month in APTC.

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You remain eligible for cost-sharing reductions.

You are ineligible for Medicaid.

Legal Authority

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A Copy of this Decision Has Been Provided To:

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