



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

## Notice of Decision

Decision Date: September 12, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000007688

[REDACTED]

Dear [REDACTED],

On August 16, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's December 20, 2015 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.

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## Decision

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NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000007688



## 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 \$263.00 per month in advance payments of the premium tax credit, effective January 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

On October 22, 2015, NY State of Health (NYSOH) issued a renewal notice stating it's time to renew your health coverage for 2016. The notice stated there was not enough information from state and federal data sources to determine if you still qualify for financial assistance. You were asked to update the information in your account by December 15, 2015, or the financial assistance you were currently receiving could end.

On December 19, 2015, NYSOH received your completed application for health insurance.

On December 20, 2015, an eligibility determination notice was issued finding you newly eligible to receive advance premium tax credits up to \$263.00 per month

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as well as cost sharing reductions effective January 1, 2016. The determination was based on your attested household income of \$24,015.00.

On December 20, 2015, a disenrollment notice was issued terminating your coverage in your Medicaid Managed Care plan effective December 31, 2015.

On January 20, 2016, an enrollment confirmation notice was issued confirming your enrollment in a Silver level qualified health plan effective March 1, 2016.

On March 4, 2016, you contacted NYSOH's Account Review Unit and requested an appeal in order to dispute the level of APTC and Cost Sharing reductions you were found eligible to receive.

On August 16, 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) You were previously found eligible for Medicaid effective January 1, 2015, and enrolled in to a Medicaid Managed Care plan effective February 1, 2015.
- 4) You testified you are a [REDACTED], and are self-employed.
- 5) The application that was submitted on December 19, 2015, listed annual household income of \$24,015.00, consisting of earned income from your self-employment. You testified that this amount was correct.
- 6) You provided documentation showing your bank account for your business for the month of January, 2016.
- 7) You testified, and provided documentation, that your monthly income for January was \$2,594.60. (Appellant's Exhibit 1 pg. 1) Document: [REDACTED]

- 8) Your application states that you will not be taking business deductions on your 2016 tax return, however, your 2015 tax return shows you did take deductions.
- 9) Your Schedule C profit or loss from business for 2015 shows you took \$5,885.00 in losses to your business, and a net profit of \$7,475.00. This information was not included on your December 19, 2015 application. (Appellant's Exhibit 2 pg 1). Document: [REDACTED]
- 10) You testified you were not sure how much in tax deductions you would be taking for your private business for 2016.
- 11) Your application states that you live in Albany 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 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).

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 2015 FPL, which is \$11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

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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).

### MAGI

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)).

“Adjusted gross income” means, in the case of an individual taxpayer, gross income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from time savings accounts, and deductions attributable to royalties (26 USC § 62(a)).

### Business Expense Deductions

Subject to some limitations, deductions that are attributable to a trade or business may be deductions from a taxpayers adjusted gross income (26 USC § 62 (a)(1)).

## **Legal Analysis**

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to \$263.00 per month.

The application that was submitted on December 19, 2015, listed an annual household income of \$24,015.00 and the eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2016 income taxes as married filing jointly and will claim no dependents on that tax return.

You reside 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 \$24,015.00 is 204.04% of the 2015 Federal Poverty Level (FPL) for a one-person household. At 204.04% of the FPL, the expected

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contribution to the cost of the health insurance premium is 6.55% of income, or \$131.08 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 (\$131.08 per month), which equals \$262.55 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$263.00 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 \$24,015.00 is 204.04% 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 \$11,770.00 for a one-person household. Since \$24,015.00 is 204.04% of the 2015 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.

You provided documentation showing your bank account for your business for the month of January, 2016. That documentation showed that your monthly income for January was \$2,594.60. (Appellant's Exhibit 1 pg. 1) Document:

[REDACTED]

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 \$1,354.00 per month. Since the documentation you provided shows that you earned \$2,594.00 for the month of January, 2016, you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Your December 19, 2015, application states that you will not be taking business deductions on your 2016 tax return, however, your 2015 tax return shows you did take deductions the previous year. You testified that you were not sure how

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much you would be taking in deductions for 2016. Since you only provided a bank record for the month of January, without describing what actual deductions were business related, a determination cannot be made whether you would qualify for additional financial assistance for 2016.

Since the December 19, 2015, eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$263.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

If you wish to include your expected deductions for 2016 you may contact NYSOH and submit an updated application. NYSOH will then determine your eligibility accordingly.

## **Decision**

The December 19, 2015 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** September 12, 2016

## **How this Decision Affects Your Eligibility**

You remain eligible for up to \$263.00 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

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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 December 19, 2015 eligibility determination notice is AFFIRMED.

You remain eligible for up to \$263.00 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:**

