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

Notice of Decision

Decision Date: September 6, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000007941

[redacted]

Dear [redacted],

On August 31, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's March 15, 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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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 $0.00 per month in advance payments of the premium tax credit, effective April 1, 2016?
>
> Did NY State of Health properly determine that you were not eligible for cost-sharing reductions, effective April 1, 2016?
>
> Did NY State of Health properly determine that you were not eligible to enroll in the Essential Plan, effective April 1, 2016?
>
> 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 due to end on February 29, 2016.

On January 14, 2016, NYSOH issued a notice stating that it was time to renew your health insurance for the upcoming coverage year. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by February 15, 2016, or you might lose the financial assistance you were currently receiving.

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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 not eligible for Medicaid, Child Health Plus, the Essential Plan or to receive tax credits to help pay for the cost of your insurance, and could not enroll in a qualified health plan at full cost. 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. The notice further stated that your eligibility would end effective February 29, 2016.

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 15, 2016, NYSOH received your completed application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating you were eligible to purchase a qualified health plan at full cost through NYSOH, effective April 1, 2016, and that you qualified to select a health plan outside of the open enrollment period for 2016. You were given until May 14, 2016 to select a health plan.

Also on March 15, 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.

On March 16, 2016, NYSOH issued an eligibility redetermination notice based on the information contained in the March 15, 2016 application, stating that you were eligible to purchase a qualified health care plan at full cost. The notice also stated that you did not qualify for Medicaid, Child Health Plus, the Essential Plan, to receive a tax credit or receive cost-sharing reductions because the income stated in your application was over $47,080.00, which is above the allowable income limit for these programs.

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 15, 2016 listed annual household income of $48,177.00, consisting of wages you earn from your employment. You testified that this amount was correct.

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

5) You testified you are seeking financial assistance because you are in a probationary period at your present employer and are not eligible for health insurance.

6) Your application states that you live in New York County, New York.

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).

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)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). 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

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).

Legal Analysis

The first issue is whether NYSOH properly determined that you were not eligible for APTC.

You testified that your income of $48,177.00 listed on the application submitted on March 15, 2016 was correct 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 New York County, where the second lowest cost silver plan available for an individual through NYSOH costs $368.26 per month.

An annual income of $48,177.00 is 409.32% of the 2015 FPL for a one-person household. In order to be eligible for an advance premium tax credit, a person cannot have a household income greater than 400.00% of the FPL. Since your annual household income of $48,177.00 is greater than 400.00% of the FPL, NYSOH correctly found you to be ineligible to receive APTC.

The second issue is whether you were properly found ineligible 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 $48,177.00 is 409.32% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue is whether NYSOH properly determined that you were ineligible for the Essential Plan.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% 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 an annual household income of $48,177.00 is 409.32% of the 2015 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The last 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 $48,177.00 is 405.53% 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 16, 2016 eligibility determination notice properly stated that, based on the information you provided, you were ineligible for APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The March 16, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 6, 2016

How this Decision Affects Your Eligibility

You were eligible to purchase a qualified health plan at full cost effective April 1, 2016.

You are not eligible for APTC or cost sharing reductions.

You are not eligible for the Essential Plan.

You are not eligible 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 16, 2016 eligibility determination notice is AFFIRMED.

You were eligible to purchase a qualified health plan at full cost effective April 1, 2016.

You are not eligible for advance premium tax credits or cost sharing reductions. .

You are not eligible for the Essential Plan.

You are not eligible 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:

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