



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

Notice of Decision

Decision Date: October 27, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000008349

[REDACTED]

Dear [REDACTED],

On October 4, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's March 26, 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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Decision

Decision Date: October 27, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000008349



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 \$211.00 per month in advance payments of the premium tax credit (APTC), effective May 1, 2016?

Did NY State of Health properly determine that you were eligible for cost-sharing reductions (CSR), effective May 1, 2016?

Did NY State of Health properly determine that you were not eligible for the Essential Plan?

Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On March 25, 2016, NY State of Health (NYSOH) received your updated application for health insurance.

On March 26, 2016, NYSOH issued an eligibility determination notice based on the information contained in the March 25, 2016 application, stating that you were eligible to receive up to \$211.00 per month in APTC, and eligible for CSR, effective May 1, 2016. The notice also stated that you were not eligible for Medicaid or the Essential Plan because your income was over the allowable income limits.

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On March 28, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not determined to be eligible for a greater amount of financial assistance.

On October 4, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing kept open for fifteen days at the end of the hearing to give you the opportunity to submit your paystubs for the period of April 1, 2016 through the present. On October 19, 2016, you faxed a thirteen page document to the NYSOH Appeals Unit. The record is now closed.

Findings of Fact

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

- 1) You testified that you filed this appeal because you felt you could not afford the premiums for health insurance after the tax credit was applied, and because you felt the projected income figure that was used to determine your eligibility was not a reliable figure, since you felt your job and income were unstable.
- 2) The record reflects that you expect to file your 2016 tax return with a filing status of single, and to claim no dependents on your tax return.
- 3) The application that was submitted on March 25, 2016 listed expected annual household income of \$24,960.00, consisting of earned income. You testified that this amount was more or less correct at that time.
- 4) You testified that you were laid off from the position you had at the time of your application, and that your last day at that job was May 6, 2016.
- 5) You testified that you believe you received your last paycheck from that job approximately two weeks after your last day.
- 6) You testified that you began another position on July 11, 2016. However, you testified that you did not achieve a required passing grade on an assessment for that position, and that you were let go as of July 27, 2016.
- 7) You testified that you filed for Unemployment Insurance Benefits after that position ended, but that you have not yet begun to receive any benefits.
- 8) The record contains a five-page document faxed to NYSOH on September 27, 2016. The second page of that document is a NY State Department of Labor Unemployment Insurance Monetary Benefit Determination showing

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a claim effective date of July 25, 2016, and a weekly benefit rate of \$177.00.

- 9) You testified that you are currently employed through a temporary staffing agency at a position that started on August 30, 2016 and will end by November 1, 2016.
- 10) You testified that your temporary job pays \$10.00 an hour, and that you work up to four and a half hours per day, Monday through Friday. You further testified that you are sometimes only asked to come in three or four days out of the week.
- 11) After the hearing, you faxed a thirteen page document to the NYSOH Appeals Unit consisting of the following:
 - a. A one-page cover sheet;
 - b. A direct deposit paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$966.36;
 - c. A direct deposit paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$965.76;
 - d. A direct deposit paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$901.14;
 - e. A direct deposit paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$961.44;
 - f. A paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$976.73;
 - g. A paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$436.23;
 - h. A paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$225.00;
 - i. A paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$135.00;
 - j. A paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$180.00;
 - k. A paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$180.00;
 - l. A paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$180.00;
 - m. A paystub from [REDACTED] with a check date of [REDACTED] for gross pay of \$180.00.

Taken together, these documents are entered into the record as "Appellant's Exhibit One."

- 12) Your application states that you will not be taking any deductions on your 2016 tax return, and you confirmed this in your testimony.

13) You requested “Aid to Continue” pending the outcome of your appeal. The record reflects that this request was granted, and that you were reinstated into your Fee-For-Service Medicaid as of April 1, 2016, and your Medicaid Managed Care plan as of May 1, 2016.

14) Your application states that you live in Erie 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 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).

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)).

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 (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 APTC of up to \$211.00 per month, effective May 1, 2016.

The application that was submitted on March 25, 2016 listed an annual household income of \$24,960.00, and the eligibility determination relied upon that information.

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

You reside in Erie County, where the second lowest cost silver plan available for an individual through NYSOH costs \$353.19 per month.

An annual income of \$24,960.00 is 212.06% of the 2015 FPL for a one-person household. At 212.06% of the FPL, the expected contribution to the cost of the health insurance premium is 6.84% of income, or \$142.27 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 (\$353.19 per month) minus your expected contribution (\$142.27 per month), which equals \$210.92 per month. Therefore, rounding to the nearest

dollar, NYSOH correctly determined you to be eligible for up to \$211.00 per month in APTC, effective May 1, 2016.

The second issue is whether you were properly found eligible for CSR. CSR are available to a person who has a household income no greater than 250% of the FPL. Since a household income of \$24,960.00 is 212.06% of the applicable FPL, NYSOH correctly found you to be eligible for CSR, effective May 1, 2016.

The third issue under review is whether NYSOH properly determined that you were not eligible 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 \$24,960.00 is 212.06% of the 2015 FPL, NYSOH properly found you to be ineligible for the Essential Plan as of your March 25, 2016 application.

The fourth issue is whether NYSOH properly determined that you were not eligible 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 \$24,960.00 is 212.06% 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, you testified that the job on which the expected annual income in your March 25, 2016 application was based came to an end on May 6, 2016. You further testified that your income was not always consistent at that job, and became even less consistent after that position ended. After the hearing, your submitted documentation to show your income from April 1, 2016 to the present.

Financial eligibility for Medicaid can be determined on a monthly income basis. The documentation that you submitted indicates that your gross monthly income for April 2016 was \$2,833.26 (See Appellant's Exhibit One). Since \$2,833.26 is 286.19% of the 2016 monthly FPL for a household of one, you were over income for Medicaid for the month of April 2016.

However, you credibly testified that this employment came to an end on May 6, 2016. The documentation you submitted shows one paystub from May 13, 2016 in the amount of \$961.44 (See Appellant's Exhibit One). You credibly testified

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that you had no other income in May 2016. Additionally, your paystubs after May 2016 are entirely consistent with your testimony regarding the job you temporarily took in July 2016, and the current position you are working at a temporary staffing agency.

Since \$961.44 is 97.12% of the 2016 monthly FPL for a household of one, your income as of May 2016 was below the income limit for Medicaid. Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid on a monthly income basis effective May 1, 2016, based on a household of one with a monthly income of \$961.44.

Decision

The March 26, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid on a monthly income basis effective May 1, 2016, based on a household of one with a monthly income of \$961.44.

Effective Date of this Decision: October 27, 2016

How this Decision Affects Your Eligibility

You were eligible for \$211.00 in APTC and eligible for CSR, effective May 1, 2016, based on the information in your March 25, 2016 application.

However, based on the income information you provided at the hearing, your case is being RETURNED to NYSOH to redetermine your eligibility for Medicaid effective May 1, 2016 on a monthly income basis.

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.

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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 26, 2016 eligibility determination notice is **AFFIRMED**.

You were eligible for \$211.00 in APTC and eligible for CSR, effective May 1, 2016, based on the information in your March 25, 2016 application.

However, based on the income information you provided at the hearing, your case is being **RETURNED** to NYSOH to redetermine your eligibility for Medicaid on a monthly income basis effective May 1, 2016, based on a household of one with a monthly income of \$961.44.

Legal Authority

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A Copy of this Decision Has Been Provided To:

