



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

Notice of Decision

Decision Date: November 7, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000009057

[REDACTED]

Dear [REDACTED]

On November 1, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health’s April 1, 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 up to \$242.00 per month in advance payments of the premium tax credit, effective May 1, 2016?

Did NY State of Health properly determine that you were eligible for cost-sharing reductions?

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

Procedural History

On March 31, 2016, NY State of Health (NYSOH) received your completed application for health insurance.

On April 1, 2016, NYSOH issued an eligibility determination notice based on the information contained in the March 31, 2016 application, stating that you were eligible for \$242.00 per month in advance premium tax credits (APTC) and cost-sharing reductions (CSR). This notice also stated that you were not eligible for Medicaid because your income was over the allowable income limit for that program.

On April 21, 2016, you spoke with NYSOH's Account Review Unit and appealed that determination insofar as it did not find you eligible for a greater amount of financial assistance.

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On November 1, 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 31, 2016 listed annual household income of \$25,987.25, consisting of \$25,987.25 you earn from your employment. You testified that this amount was correct at the time of the application, but your income is now higher due to your hourly rate of pay increasing from \$12.15 per hour to \$13.30 per hour.
- 4) You testified that your monthly income for March 2016 was \$12.15 per hour multiplied by 80 hours bi-weekly.
- 5) Your application states that you will not be taking any deductions on your 2016 tax return.
- 6) You testified that although you will not be taking any deductions on your 2016 tax return, you have other expenses that should be taken into consideration when determining your eligibility. You listed these expenses as a car loan, personal loan, a line of credit, and child support.
- 7) You testified that you currently have employer-sponsored insurance in which you pay \$29.77 bi-weekly for medical and \$25.29 bi-weekly for dental. You would also like those payments taken into consideration when determining your eligibility.
- 8) Your application state that you live in Chemung 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

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).

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).

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)

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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)).

General Deductions

“Adjusted gross income” means, in the case of an individual taxpayer, gross federal taxable 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, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Child Support

Generally, payments made for the support of children are not included in the gross income of the parent receiving the payment and cannot be deducted by the parent who is making the payment. (26 USC § 71(c)(1)).

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 (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

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(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 \$242.00 per month.

In the application that was submitted on March 31, 2016, you attested to an expected yearly income of \$25,987.25, and the eligibility determination relied upon that information. During the hearing, you testified that the amount you provided in your application was correct. However, you asked that your current expenses, which include child support, a personal loan, a car payment, a line of credit, and the cost of your employer-sponsored health insurance be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as child support, a personal loan, a car payment, a line of credit and the cost of your employer-sponsored health insurance to be deducted from the calculation of your adjusted gross income, they cannot be deducted when NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, the Marketplace correctly determined your household income to be \$25,987.25.

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 Chemung County, where the second lowest cost silver plan available for an individual through NYSOH costs \$396.54 per month.

An annual income of \$25,987.25 is 220.79% of the 2015 FPL for a one-person household. At 220.79% of the FPL, the expected contribution to the cost of the health insurance premium is 7.14% of income, or \$154.62 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 (\$396.54 per month) minus your expected contribution (\$154.62 per month), which equals \$241.92 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$242.00 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 \$25,987.25 is

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220.79% of the applicable FPL, NYSOH correctly found you to be eligible for CSR.

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 \$25,987.25 is 218.74% 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, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You testified that, in March 2016, you resided in a one-person household and earned \$12.15 per hour for 80 hours bi-weekly. In order to calculate your monthly income, we multiplied your hourly wage (\$12.15) times the number of hours you work bi-weekly (80); which equals \$972.00. Then, we multiplied your bi-weekly pay (\$972.00) times 26 weeks to determine your annual income; which equals \$25,272.00 per year; then divided your annual income by 12; which equals \$2,106.00. Therefore, according to your testimony, your income for the month of March 2016 was \$2,106.00.

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 \$1,366.20 per month for a one-person household. Since the record indicates that you earned \$2,106.00 in March 2016 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the April 1, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$242.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The April 1, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 7, 2016

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How this Decision Affects Your Eligibility

The determination made on April 1, 2016 was proper and you were eligible \$242.00 per month in APTC and cost-sharing reductions.

You remain 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

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Summary

The April 1, 2016 eligibility determination notice is AFFIRMED.

The determination made on April 1, 2016 was proper and you were eligible \$242.00 per month in APTC and cost-sharing reductions.

You remain 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:

