



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

## Notice of Decision

Decision Date: November 22, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000009303

[REDACTED]

Dear [REDACTED],

On October 31, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's April 30, 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 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).

This page intentionally left blank.



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

## Decision

Decision Date: November 22, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000009303



## Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to \$238.00 per month in Advanced Premium Tax Credits (APTC), effective July 1, 2016?

Did NYSOH 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 April 29, 2016, NYSOH received your updated application for financial assistance. That day, a preliminary eligibility determination was prepared with regard to that application, stating that you were eligible to receive APTC in the amount of \$238.00 per month and cost-sharing reductions, effective July 1, 2016.

Also on April 29, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the preliminary eligibility determination insofar as you were not eligible for Medicaid and/or additional subsidies.

On April 30, 2016, NYSOH issued an eligibility redetermination based on the April 29, 2016 application, stating that you were eligible to receive APTC in the amount of \$238.00 per month, effective July 1, 2016. The notice further stated that you were eligible to receive cost-sharing reductions which can help lower the

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).

amount you pay out of pocket for deductibles, co-insurance, and co-payments if you select a silver level qualified health plan.

On October 28, 2016 you were scheduled to have a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. That day a Hearing Officer called you but you were unable to go forward with your scheduled hearing. You requested an adjournment and it was granted.

On October 31, 2016, you had an adjourned telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open for you to submit documentation establishing your income for the month of April 2016. No such documentation was received and the record was closed at the end of business on November 15, 2016.

## **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 April 29, 2016, which requested financial assistance, listed annual household income of \$23,920.00, consisting solely of monies you earn from your employment. You testified that this amount was correct.
- 4) You testified that you did not know what your income was for the month of April 2016. You did not provide any documentation of your income for April and there is no evidence in the record.
- 5) Your application states that you will not be taking any deductions on your 2016 tax return.
- 6) Your application states that you live in Queens 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).

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).

## 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 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).

## Affordability Exemption

Under some circumstances, a person may receive an exemption from paying a penalty for not purchasing health insurance coverage. Such an exemption may be granted if that person can show that he or she experienced a financial hardship or has domestic circumstances that (1) caused an unexpected increase in essential expenses that prevented that person from obtaining health coverage under a QHP; (2) would have caused the person to experience serious deprivation of food, shelter, clothing, or other necessities, as a result of the expense of purchasing health coverage under a QHP; or (3) prevented that person from obtaining coverage under a QHP (45 CFR § 155.605(a), (d)).

NYSOH has deferred to the U.S. Department of Health and Human Services (HHS) on the matter of hardship exemptions (see 45 CFR § 155.505(c)).

## Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for APTC of up to \$238.00 per month.

The application that was submitted on April 29, 2016 listed an annual household income of \$23,920.00 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 Queens County, where the second lowest cost silver plan available for an individual through NYSOH costs \$368.26 per month.

An annual income of \$23,920.00 is 203.23% of the 2015 FPL for a one-person household. At 203.23% of the FPL, the expected contribution to the cost of the health insurance premium is 6.52% of income, or \$130.05 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 (\$368.26 per month) minus your expected contribution (\$130.05 per month), which equals \$238.21 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$238.00 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 \$23,920 is 203.23% 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 \$23,920.00 is 201.35% 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

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).

family size. You failed to submit documentation establishing your income for the month of the application at issue, April 2016. Therefore, there is insufficient information in the record to determine your financial eligibility for Medicaid on the basis of your monthly household income.

Since the April 30, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$238.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

If you wish to be considered for a hardship exemption, which would exempt you from paying a penalty for not having health insurance during 2015, you can check the Federal Marketplace website ([www.healthcare.gov](http://www.healthcare.gov)) for an application.

## **Decision**

The April 30, 2016 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** November 22, 2016

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

You remain eligible for up to \$238 in monthly APTC.

You are 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

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).



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 April 30, 2016 eligibility determination notice is AFFIRMED.

You remain eligible for up to \$238 in monthly APTC.

You are 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:**

