



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

**Notice of Decision**

Decision Date: December 12, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000009560

[REDACTED]

Dear [REDACTED],

On November 30, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health’s April 28, 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: December 12, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000009560



## 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 \$239.00 per month in advance payments of the premium tax credit, effective June 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 April 27, 2016, NY State of Health (NYSOH) received your updated application for health insurance.

On April 28, 2016, NYSOH issued an eligibility determination notice based on the information contained in the April 27, 2016 application, stating that you were eligible for \$239.00 per month in advance payments of the premium tax credit (APTC) and eligible to receive cost sharing reductions. You were not eligible for Medicaid because your income was over the allowable income limit for that program.

On May 12, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not found eligible for Medicaid.

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On November 30, 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 April 27, 2016 listed annual household income of \$25,273.00, consisting of \$10,383.00 thus far you have withdrawn during 2016 from your [REDACTED] Individual Retirement Account. You testified that these 2016 withdrawals are untaxed and that these amounts were correct.
- 4) You testified, and provided documentation, that your only income during April 2016 was a withdrawal in the amount of \$2,106.08 from your Individual Retirement Account.
- 5) Your application states that you will not be taking any deductions on your 2016 tax return.
- 6) You testified that in October 2016 you began full-time employment earning \$540.00 per week as a caregiver and that you do not know how long the employment would continue.
- 7) Your application states that you live in Nassau County.
- 8) You testified that you are seeking Medicaid eligibility.

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

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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 2051 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

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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 (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

### 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) 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 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 (including taxable amounts from Individual Retirement Accounts) (26 USC § 62(a)). Distributions from traditional Individual Retirement Accounts are taxable in the year that they are received (IRS Publication 590-B).

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## Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of \$239.00 per month.

The application that was submitted on listed an annual household income of \$25,273.00 and the eligibility determination relied upon that information. You testified that your sole source of income through October 2016 was pre-tax distributions from your Individual Retirement Account. Pursuant to IRS Publication 590-B, these distributions are considered taxable income in the year that they are received and as such are included in a person's Modified Adjusted Gross Income.

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 Nassau County, where the second lowest cost silver plan available for a primary subscriber through NYSOH costs \$385.22 per month.

An annual income of \$25,273.00 is 214.72% of the 2016 FPL for a one-person household. At 214.72% of the FPL, the expected contribution to the cost of the health insurance premium is 6.93% of income, or \$145.00 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 a primary subscriber in your county (\$385.22 per month) minus your expected contribution (\$145.95 per month), which equals \$239.27 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$239.00 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 \$25,273.00 is 214.72% 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 \$25,273.00 is 212.73% of the

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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 submitted an Individual Retirement Account statement from [REDACTED] that shows in April 2016 you received \$2,106.08. As discussed above, payments received from an Individual Retirement Account are counted as income for purposes of determining eligibility for financial assistance through NYSOH.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have a monthly income no greater than 138% of the FPL, which is \$1,367.00 per month. Since the documentation you provided shows that you earned \$2,106.08 in April 2016 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the April 28, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$239.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

## **Decision**

The April 28, 2016 eligibility determination notice is AFFIRMED.

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

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

You remain eligible for up to \$239.00 in APTC.

You are eligible for cost-sharing reductions.

You are ineligible for Medicaid.

## **If You Disagree with this Decision (Appeal Rights)**

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 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 eligibility determination notice is AFFIRMED.

You remain eligible for up to \$239.00 in APTC.

You are eligible for cost-sharing reductions.

You are ineligible for Medicaid.

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## **Legal Authority**

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**A Copy of this Decision Has Been Provided To:**

