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

Notice of Decision

Decision Date: January 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000011419

[redacted]

[redacted]

On January 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 30, 2016 eligibility determination notice.

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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NY State of Health Account ID: [redacted]
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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 (NYSOH) properly calculate the amount of Modified Adjusted Gross Income used when determining your eligibility for financial assistance?

Did NYSOH properly determine that you were ineligible to receive advance payments of the premium tax credit (APTC), effective September 1, 2016?

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

Did NY State of Health properly determine that you were ineligible for the Essential Plan?

Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On July 6, 2016, NYSOH received your completed application for health insurance.

On July 7, 2016, NYSOH issued a notice advising you that additional information in the form of income documentation was required to confirm your eligibility for

health insurance through NYSOH. This notice requested that you submit income documentation by July 21, 2016.

On July 22, 2016, income documentation was uploaded to your NYSOH account.

On July 29, 2016, NYSOH redetermined your eligibility for financial assistance with health insurance.

On July 30, 2016, NYSOH issued a notice of eligibility redetermination stating that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective September 1, 2016. This notice also stated that you did not qualify for Medicaid, the Essential Plan, or to receive a tax credit to help pay for the cost of coverage.

On August 12, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination as it related to your eligibility for financial assistance with health insurance.

On January 4, 2017, 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) The application that was submitted on July 6, 2016 listed an expected yearly income for 2016 of $3,000.00. That application also indicated that you would be claiming no dependents on your 2016 tax return.

2) You testified that you expect to file your 2016 taxes with a tax filing status of single. You testified that you are not yet sure if you will claim any dependents on that tax return.

3) You testified that you are seeking insurance for yourself.

4) You testified that you are not yet sure of what your 2016 income was, but you approximate your 2015 income at $27,000.00 or $28,000.00.

5) You testified that you worked for [redacted] from the beginning of 2016 until December 27, 2016.

6) You testified that you were paid biweekly. You testified that your income would fluctuate based on factors such as over-time and commission. You

testified that your base rate of pay was $13.75 per hour and you typically worked 40 hours per week.

7) On July 22, 2016 two paystubs were uploaded to your NYSOH account. The first is for pay date June 17, 2016 for a gross pay amount of $2,883.89, and the second is for pay date July 1, 2016 for a gross pay amount of $1,264.64. The July 1, 2016 paystub indicates a gross year to date amount of $22,381.78. These paystubs each show a biweekly deduction of $165.23 for child support. The paystubs also show an hourly base rate of $15.5675.

8) On July 29, 2016, NYSOH redetermined your expected annual household income to be $53,930.89 based on the paystubs you submitted.

9) You testified that the $2,883.89 payment of wages represents overtime and commissions, and is not indicative of your usual earnings.

10) You testified that you are responsible for making child support payments, and would like this taken into account.

11) You testified that you will not be taking any deductions on your 2016 tax return.

12) You testified that you currently reside in Monroe County, and did so throughout 2016.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

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)).

Generally, payments made for the support of children cannot be deducted from the gross income of the parent making the payments (26 USC § 71(c)(1)).

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)).

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).

Legal Analysis

The first issue is whether NYSOH properly calculated the amount of Modified Adjusted Gross Income used when determining your eligibility for financial assistance.

On July 6, 2016, your application listed an annual household income of $3,000.00. At that time, NYSOH requested that you submit income documentation as this information did not match what was available from State and Federal data sources.

On July 22, 2016, income documentation in the form of two paystubs was uploaded to your NYSOH account. Based upon this income documentation, NYSOH redetermined your annual household income on July 29, 2016 to be $53,930.89. The paystubs you submitted show four weeks of earnings totaling a gross of $4,148.53, for a weekly average of $1,037.13. Therefore, accounting for 52 weeks at $1,037.13 yields gross projected earnings of $53,930.89.

At the hearing you testified that you are not sure of what your 2016 gross earnings were, however, you believe your gross earnings will be around $27,000 or $28,000. However, the paystub from July 1, 2016, which is 26 weeks into 2016, shows a gross year to date income of $22,381. You further testified that your base rate of pay was $13.75 per hour, and that you worked 40 hours per week. However, the paystubs you submitted indicate a base rate of pay of $15.5675.

As your testimony was inconsistent with the information contained on the paystubs you submitted, there is insufficient proof to disturb the calculation by NYSOH that your expected annual income for 2016 is $53,930.89.

You further testified that you are responsible for making child support payments. Your paystubs reflect that $165.23 is deducted from your biweekly pay for child support. However, child support is not deducted from the gross income of the parent making the payments. Therefore, the amount you pay in child support is properly included when determining your Modified Adjusted Gross Income.

The second issue is whether NYSOH properly determined that you were ineligible for APTC.

On July 29, 2016, NYSOH redetermined your household income to be $53,930.89. 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.

APTC is available to a person who has a household income no greater than 400% of the FPL. Since a household income of $53,930.89 is 458.21% of the 2016 FPL, NYSOH correctly found you to be ineligible for APTC.

The third 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 $53,930.89 is 458.21% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue under review 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 $458.21 is 458.21% of the 2015 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth 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 $53,930.89 is 453.96% of the 2016 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis.

Since the July 30, 2016 eligibility determination properly stated that, based on the income documentation you provided, you were ineligible for APTC, ineligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The July 30, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 11, 2017

How this Decision Affects Your Eligibility

You are ineligible for APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

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 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):

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).

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

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  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The July 30, 2016 eligibility determination notice is AFFIRMED.

You are ineligible for APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

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:

[redacted]

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