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

Notice of Decision

Decision Date: February 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000011449

[redacted]

Dear [redacted],

On January 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

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NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000011449

[redacted]

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 $0.00 per month in advance payments of the premium tax credit (APTC), effective August 1, 2016?
>
> Did NYSOH properly determine you were not eligible for cost-sharing reductions (CSR)?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On April 28, 2015, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective April 1, 2015. You were subsequently enrolled into a Medicaid Managed Care plan.

On June 15, 2016, NYSOH issued a notice that it was time to renew your health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by July 15, 2016, or you might lose the financial assistance you were currently receiving.

On June 27, 2016, NYSOH received your updated application for health insurance.

On June 28, 2016, NYSOH issued an eligibility determination notice based on the information contained in the June 27, 2016 application, stating that you were newly eligible to receive $0.00 in APTC, effective August 1, 2016. The notice also stated that you were not eligible for CSR or for Medicaid because your expected annual household income was over the respective allowable income limits for those programs.

Also on June 28, 2016, NYSOH issued a disenrollment notice, stating that your enrollment in your Medicaid Managed Care plan was ending effective July 31, 2016.

On August 15, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the June 28, 2016 eligibility determination, insofar as you were not found eligible for Medicaid. You also requested Aid to Continue, pending the outcome of your appeal.

On September 2, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for a limited time, effective August 1, 2016, because you have been granted Aid to Continue until a decision is made on your appeal. You were also re-enrolled into your Medicaid Managed Care plan as of August 1, 2016, as a result of the granting of your Aid to Continue request.

On January 10, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open for fifteen days at the end of the hearing to provide you with the opportunity to provide documentation of your claim for Unemployment Insurance Benefits (UIB), and the UIB payments that you have received. On January 17, 2017, you faxed a four-page document to NYSOH. The record is now closed.

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 married filing jointly. You will claim one dependent on that tax return.

2) This appeal is on behalf of yourself only.

3) The application that was submitted on June 27, 2016 listed annual household income of $65,130.00, consisting of $44,330.00 in expected annual income from your employment, $20,800.00 in expected annual earned income for your spouse.

4) You testified that this amount was probably correct at the time of your application.

5) You testified that your job ended on October 28, 2016, and you are not working at this time.

6) You testified that you worked full time in the month of August 2016, and worked the full month.

7) You testified that you were earning $850.52 per week, gross, before your job ended.

8) You testified that you filed for UIB and received three payments of $430.00, but that the payments have stopped, and you think your former employer is fighting your eligibility.

9) After the hearing, you faxed a four-page document to the Appeals Unit consisting of the following:

    a. Two pages of a UIB Monetary Benefit Determination from the NYS Department of Labor, dated December 2, 2016, which state that your claim effective date is November 28, 2016, and that you will receive $430.00 per week in UIB, if you are found eligible for benefits;
    b. A one-page document from the NYS Department of Labor addressed to you which explains how you can access your UIB with a [redacted];
    c. A one-page document from [redacted] explaining how your personal information is used.

    These documents are collectively marked and entered into the record as "Appellant's Exhibit One."

10) You testified that your spouse's income was approximately correct, as you believe it was $19,000.00 for the year 2016.

11) Your application states that you will not be taking any deductions on your 2016 tax return, and you testified that this is correct.

12) Your application states that you live in [redacted] 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

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 $20,090.00 for a three -person household (80 Federal Register 3236, 3237).

For annual household income in the range of at least 300% but less than 400% of the 2015 FPL, the expected contribution is 9.66 % 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

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 $20,160.00for a three-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 under review is whether NYSOH properly determined that you were eligible for an APTC of $0.00 per month.

The application that was submitted on June 27, 2016 listed an annual household income of $65,130.00 and the eligibility determination relied upon that information.

You are in a three-person household. You expect to file your 2016 income taxes as married filing jointly and will claim one dependent on that tax return.

You reside in [redacted] County, where the second lowest cost silver plan available for an individual subscriber through NYSOH costs $368.26 per month.

An annual income of $65,130.00 is 324.19% of the 2015 FPL for a three-person household. At 324.19% of the FPL, the expected contribution to the cost of the health insurance premium is 9.66% of income, or $524.30 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 subscriber in your county ($386.26 per month) minus your expected contribution ($524.30 per month). Since this results in a negative number, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $0.00 per month in APTC.

The second issue under review is whether you were properly found ineligible 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 $65,130.00 is 324.19% of the applicable FPL, NYSOH correctly found you to be ineligible for CSR.

The third issue under review 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 $20,160.00 for a three-person household. Since $65,130.00 is 308.44% 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 you were working full time in August 2016, earning $850.52, gross, per week and that your spouse was also working.

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 $2,318.00 per month. Since, according to your testimony, your income alone was approximately $3,402.08 for the month, you do not qualify for Medicaid on the basis of monthly income as of the month when your new eligibility began.

You testified at the hearing that your income has changed since your application, as you stopped working as of October 28, 2016. You testified that you filed for UIB, and received three payments of $430.00 each. The record was left open at the end of the hearing so that you could provide proof of your claim for UIB, and the payments you received. After the hearing, you faxed a UIB Monetary Benefit Determination to the Appeals Unit, showing that your claim effective date was November 28, 2016, and that your weekly benefit rate would be $430.00, if you were approved for benefits (See Appellant's Exhibit One). No further documentation was received by NYSOH.

Since you did not submit documentation to show what UIB payments you have received, nor documentation to show that you are no longer receiving UIB, there is not enough information in the record to warrant sending your case back to NYSOH for a redetermination of your eligibility.

Therefore, since the June 27, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for $0.00 per month in APTC, ineligible for cost-sharing reductions, and ineligible for Medicaid, it was correct and is AFFIRMED.

If you wish to have your eligibility redetermined based on your current household income, you must update your NYSOH account and submit documentation of your current household income, including proof of your UIB payments.

Decision

The June 27, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 10, 2017

How this Decision Affects Your Eligibility

You were eligible for $0.00 in APTC as of August 1, 2016.

You were not eligible for CSR as of your June 27, 2016 application.

You were not eligible for Medicaid as of your June 27, 2016 application.

If you wish to find out your current eligibility for financial assistance, you must update your NYSOH application and submit documentation of your current income, including information regarding any UIB payments you are receiving.

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

Summary

The June 27, 2016 eligibility determination notice is AFFIRMED.

You were eligible for $0.00 in APTC as of August 1, 2016.

You were not eligible for CSR as of your June 27, 2016 application.

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 were not eligible for Medicaid as of your June 27, 2016 application.

If you wish to find out your current eligibility for financial assistance, you must update your NYSOH application and submit documentation of your current income, including information regarding any UIB payments you are receiving.

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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