



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

## Notice of Decision

Decision Date: February 8, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000012372

[REDACTED]

Dear [REDACTED],

On January 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 4, 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.

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## Decision

Decision Date: February 8, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000012372



## 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 \$297.00 per month in advance payments of the premium tax credit, effective November 1, 2016?

Did NYSOH properly determine that you were eligible for cost-sharing reductions?

Did NYSOH properly determine that you were not eligible for Medicaid?

## Procedural History

On October 4, 2016, NYSOH received your completed application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating that you were eligible to receive an advance premium tax credit (APTC) of up to \$297.00 per month and, if you selected a silver-level plan, eligible for cost-sharing reductions (CSR), effective November 1, 2016.

Also on October 4, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not found eligible for an additional amount of APTC or, in the alternative, Medicaid.

On October 9, 2016, NYSOH issued an eligibility determination notice based on the information contained in the October 4, 2016 application, stating that you were eligible to receive an APTC of up to \$297.00 per month and, if you selected a silver-level plan, eligible for CSR, effective November 1, 2016.

On January 12, 2017, NYSOH received a letter issued by the [REDACTED] [REDACTED] stating that a discontinuous of medical insurance could be detrimental to your treatment.

On January 20, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: (1) statements issued by [REDACTED] [REDACTED] reflecting the two early withdrawals you received from your [REDACTED] (2) all earning statements issued by [REDACTED] to you during the month of October 2016 and (3) all earning statements issued by [REDACTED] to you during the month of October 2016. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier.

On January 20, 2017, you provided to NYSOH Appeals Unit through your online account: (1) a Partial Withdrawal/Policy Loan Request from [REDACTED] [REDACTED] reflecting your request for a \$10,000.00 withdrawal, (2) a statement issued by [REDACTED] confirming that you were issued \$5,718.18 on April 4, 2016, and (3) earning statements to you by [REDACTED] on November 2, 2016 and November 16, 2016.

On January 23, 2017, you provided to NYSOH Appeals Unit through your online account an earning statement issued to you by [REDACTED] on October 7, 2016.

Since these documents were not consistent with those requested by the Hearing Officer, the record was closed on February 4, 2017.

## **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 only.
- 3) The application that was submitted on October 4, 2016 listed annual household income of \$27,500.00, consisting of (1) \$1,200.00 you

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- expected to receive from [REDACTED] or its parent company, The [REDACTED] (2) \$8,800.00 you expected to receive from [REDACTED] and (3) \$17,500.00 in early withdrawals from [REDACTED]
- 4) You testified that you took out two early withdrawals from [REDACTED] during 2016. You further testified that while you could not recall precisely when you made these withdrawals, though you believed it was during April and November 2016.
  - 5) You testified that you are paid by both [REDACTED] and [REDACTED] [REDACTED] on a bi-weekly basis.
  - 6) On January 20, 2017, you provided to NYSOH Appeal Unit a Partial Withdrawal/Policy Loan Request from [REDACTED] [REDACTED] reflecting your request for a \$10,000.00 withdrawal. However, you did not provide a statement confirming that this withdrawal was completed.
  - 7) On January 20, 2017, you provided to NYSOH Appeal Unit a statement issued by [REDACTED] confirming that you were issued \$5,718.18 on April 4, 2016.
  - 8) On January 20, 2017, you provided to NYSOH Appeals Unit two earning statements issued to you by [REDACTED] reflecting that you were paid (1) \$117.57 on November 2, 2016 and (2) \$112.55 on November 16, 2016.
  - 9) On January 23, 2017, you provided to NYSOH Appeals Unit an earning statement issued to you by [REDACTED] reflecting that you were paid \$685.44 on October 7, 2016.
  - 10) Your application states that you will not be taking any deductions on your 2016 tax return.
  - 11) Your application states that you live in Ulster County, [REDACTED]
  - 12) You testified that you were seeking to be found eligible for a greater amount of APTC or, in the alternative, to be found eligible for Medicaid.
  - 13) You testified that the plans available to you through NYSOH are unaffordable without additional subsidy.

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 Fed. Reg. 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

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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

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).

## **Legal Analysis**

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to \$297.00 per month.

The application that was submitted on October 4, 2016 listed an annual household income of \$27,500.00, which was comprised of (1) \$1,200.00 you expected to receive from [REDACTED] or its parent company, [REDACTED] (2) \$8,800.00 you expected to receive from [REDACTED] and (3) \$17,500.00 in early withdrawals from [REDACTED]. The eligibility determination relied upon that information.

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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 Ulster County, where the second lowest cost silver plan available for an individual through NYSOH costs \$471.50 per month.

An annual income of \$27,500.00 is 233.64% of the 2015 FPL for a one-person household. At 233.64% of the FPL, the expected contribution to the cost of the health insurance premium is 7.60% of income, or \$174.19 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 (\$471.50 per month) minus your expected contribution (\$174.19 per month), which equals \$297.31 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$297.00 per month in APTC.

The second issue is whether you were properly found eligible for CSR.

CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of \$27,500.00 is 233.64% 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 \$27,500.00 is 231.48% 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.

The record reflects that you provided to NYSOH Appeal Unit (1) a Partial Withdrawal/Policy Loan Request from [REDACTED] reflecting your request for a \$10,000.00 withdrawal, (2) a statement issued by [REDACTED] confirming that you were issued \$5,718.18 on April 4, 2016, (3) two earning statements issued to you by [REDACTED] reflecting that you were paid \$117.57 on November 2, 2016 and \$112.55 on November 16, 2016, and (4)

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an earning statement issued to you by [REDACTED] reflecting that you were paid \$685.44 on October 7, 2016.

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 \$1,367.00 per month. However, since you provided only one earning statement issued to you by [REDACTED] during the month of October 2016 and no earning statements from [REDACTED] that were issued to you during that month, we are unable to assess your total income received during the month of October 2016.

Furthermore, while you provided one statement reflecting receipt of \$5,718.18 on April 4, 2016 in connection with one of your early withdrawals from [REDACTED] you have not provided the second statement reflecting the other early withdrawal, but merely a signed document requesting such monies. Accordingly, since we cannot determine the total income you received during the month of October 2016 from the documents you provided, we are unable to return your case to NYSOH for a redetermination of eligibility for Medicaid on a monthly income basis.

Since the October 5, 2016 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$297.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

## **Decision**

The October 5, 2016 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** February 8, 2017

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

You were properly found eligible for up to \$297.00 in APTC effective November 1, 2016 and, if you enrolled in a silver-level plan, eligible for CSR.

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.

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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 October 5, 2016 eligibility determination notice is AFFIRMED.

You were properly found eligible for up to \$297.00 in APTC effective November 1, 2016 and, if you enrolled in a silver-level plan, eligible for CSR.

You are ineligible for Medicaid.

### **Legal Authority**

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

