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

Notice of Decision

Decision Date: March 3, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000012467

[redacted]

Dear [redacted]

On January 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 8, 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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Decision

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NY State of Health Number: [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 properly determine that you were eligible to receive $0.00 per month in advance payments of the premium tax credit, effective November 1, 2016?
>
> Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid effective November 1, 2016?

Procedural History

On January 22, 2016, NY State of Health (NYSOH) issued an eligibility determination stating your household was eligible for Medicaid effective March 1, 2016. The notice stated this was because your household income of $7,650.00 is at or below the allowable limit for Medicaid.

On May 27, 2016, NYSOH issued an eligibility determination notice stating you were conditionally eligible for Medicaid effective June 1, 2016. The notice stated the determination was based on the condition you confirm your income by providing documentation before June 10, 2016. The notice further found the rest of your household no longer eligible for Medicaid, but their coverage would continue until February 28, 2017.

Also on May 27, 2016, a disenrollment notice was issued terminating your Medicaid Managed Care plan effective May 31, 2016. The notice stated this was because you were no longer eligible to remain enrolled in your current health plan.

On June 14, 2016, NYSOH issued a disenrollment notice stating your household's Medicaid Managed Care plan would be terminated effective June 30, 2016. The notice stated your Medicaid fee-for-service coverage through NYSOH would be discontinued as of June 30, 2016.

On June 30, 2016, you uploaded income documentation and updated your application.

On July 1, 2016, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid effective July 1, 2016. You were asked to provide additional information to confirm your income by July 15, 2016.

On July 19, 2016, NYSOH issued an eligibility determination notice stating you were conditionally eligible for Medicaid effective August 1, 2016. You were asked to provide proof your income before August 2, 2016.

On July 29, 2016, NYSOH issued an eligibility determination notice stating you and your spouse were eligible to receive advance premium tax credits of up to $303.00 per month effective September 1, 2016.

On August 12, 2016, an eligibility determination notice was issued stating you remained conditionally eligible for Medicaid effective September 1, 2016. You were asked to provide income documentation to confirm your eligibility by August 26, 2016.

On September 28, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of your spouse's ineligibility for Medicaid as stated in the June 14, 2016 disenrollment notice.

On September 29, 2016, NYSOH received your updated application for health insurance. That a day, a preliminary eligibility determination was prepared based upon your last application stating that you were eligible for $0.00 in advance premium tax credits effective November 1, 2016.

On October 6, 2016, a notice was issued, stating you did not make a valid appeal request because you requested an appeal more than 60 days from the date of your eligibility determination letter. The notice stated you could amend your appeal request by submitting a request within 60 days after September 27, 2016.

No amendment to this appeal was filed and your appeal AP000000012265 was dismissed on November 29, 2016.

On October 8, 2016, NYSOH issued an eligibility determination notice based on the on September 29, 2016 application, stating that you were eligible for a tax credit of $0.00 effective November 1, 2016. The notice stated that you were not eligible for Medicaid because your income was over the allowable income limit for that program.

You contacted NYSOH's Account Review Unit on October 11, 2016, and requested an appeal of the October 8, 2016 eligibility determination insofar as it determined you no longer eligible for Medicaid.

On January 26, 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) You are seeking insurance for yourself.

2) On your September 29, 2016 application you indicated that you expected to file your 2016 income tax return with a tax filing status of married filing jointly and that you would claim two children as dependents on that tax return.

3) You testified you were pregnant at the time of your September, 29, 2016 eligibility determination.

4) You were found presumptively eligible for Medicaid on June 30, July 18, and August 11, 2016. The household income amounts on those applications were $45,714.64, $51,714.64, and $53,000.00 respectively.

5) The application that was submitted on September 29, 2016 listed annual household income of $64,818.00, consisting of income your spouse earns at his employment. You testified that this amount was correct.

6) Your application states that you will not be taking any deductions on your 2016 tax return.

7) 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

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 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 $24,250.00 for a four-person household (80 Fed. Reg. 3236, 3237).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.18% and 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).

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 for Pregnant Women

In New York, a pregnant woman is eligible for Medicaid at a household income of 223% of the federal poverty level (FPL) for the applicable family size (42 CFR §435.116 (c)(2); NY Department of Social Services Administrative Directive 13ADM-03).

“Family size” means the number of persons counted as members of an individual’s household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

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 under review, that was the 2016 FPL, which is $28,440.00 for a five-person household (81 Fed. Reg. 4036).

Generally, Medicaid coverage begins on the first day of the month in which the applicant was found eligible (42 CFR § 435.915(b)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for APTC of $0.00 per month.

The application that was submitted on September 29, 2016 listed an annual household income of $64,818.00 and the eligibility determination relied upon that information.

You were in a four-person household for purposes of APTC during your application on September 29, 2016. You expected to file your 2016 income taxes as married filing jointly and were claiming two dependents on that tax return.

You reside in [redacted] County, where the second lowest cost silver plan available for an individual through NYSOH costs $393.63 per month.

Per your application, an annual income of $64,818.00 is 267.29% of the 2015 Federal Poverty Level (FPL) for a four-person household. At 267.29% of the FPL, the expected contribution to the cost of the health insurance premium is 8.69% of income, or $469.39 per month.

Since your maximum contribution to the cost of your insurance was $469.39 per month you were determined ineligible to received assistance paying the required premium responsibility of $393.63 for and individual in your county.

Therefore, NYSOH correctly determined you to be eligible for $0.00 per month in APTC.

The second 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 $64,818.00 is 267.29% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue is whether NYSOH properly determined you were ineligible or Medicaid effective November 1, 2016.

At the time of your September 29, 2016, you were pregnant with one child.

Generally, a pregnant woman and the number of children she is expected to deliver is included in determining household size for Medicaid eligibility. Since you were pregnant in September 2016 with one child, who is now one of the three dependents in your household, and resided with your spouse, your household size for purposes of this analysis was a five-person household.

In your application on September 29, 2016 you provided an annual household income of $64,818.00.

Medicaid can be provided through NYSOH to pregnant woman who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 223% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $63,422.00 for a five-person household. Since $64,848.00 is 227.91% 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.

Since the October 8, 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 is correct and is AFFIRMED.

Decision

The October 8, 2016 eligibility determination is AFFIRMED.

Effective Date of this Decision: March 3, 2017

How this Decision Affects Your Eligibility

You were eligible for $0.00 in APTC effective November 1, 2016.

You were ineligible for cost-sharing reductions effective November 1, 2016.

You were ineligible for Medicaid effective November 1, 2016.

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 October 8, 2016 eligibility determination is AFFIRMED.

You were eligible for $0.00 in APTC effective November 1, 2016.

You were ineligible for cost-sharing reductions effective November 1, 2016.

You were ineligible for Medicaid effective November 1, 2016.

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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