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

Notice of Decision

Decision Date: April 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012981

[redacted]

Dear [redacted],

On February 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 2, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 18, 2017

NY State of Health Account ID: [redacted]
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[redacted]

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 up to $229.00 per month in advance payments of the premium tax credit, effective December 1, 2016, and not Medicaid?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?

Procedural History

On November 22, 2015, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid, effective December 1, 2015.

On November 25, 2015, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan, effective January 1, 2016.

On September 16, 2016, NYSOH issued a renewal notice stating that NYSOH did not have enough information from state and federal data sources to determine if you could get help paying for your insurance. You were directed to update your account by October 15, 2016. The notice stated that if you missed the deadline, the financial assistance you were receiving might end.

On September 22, 2016, you updated your NYSOH application to reflect an expected yearly income of $14,019.00.

On September 23, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. You were directed to submit income documentation by October 7, 2016. The notice stated that if you missed the deadline, NYSOH would not be able to determine your eligibility for health coverage.

Also on September 23, 2016, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end effective October 31, 2016.

On September 28, 2016, you updated your NYSOH application and uploaded a copy of your 2015 federal income tax return to your NYSOH account.

On September 29, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. You were directed to submit income documentation by October 7, 2016. The notice stated that if you missed the deadline, NYSOH would not be able to determine your eligibility for health coverage.

On October 31, 2016, NYSOH redetermined your eligibility.

On November 1, 2016, NYSOH issued an eligibility determination stating that you were eligible to receive up to $229.00 per month in advance payments of the premium tax credit, as well as cost-sharing reductions, effective December 1, 2016.

Also, on November 1, 2016, NYSOH received your updated application for health insurance which listed an expected yearly income of $24,688.00.

Also on November 1, 2016, a preliminary eligibility determination was prepared regarding your November 1, 2016 application, stating that you were eligible to receive up to $229.00 per month in advance payments of the premium tax credit, as well as cost-sharing reductions.

Also on November 1, 2016, you contacted NYSOH’s Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the level of advance payments of the premium tax credit you were eligible to receive and seeking a redetermination of your eligibility for Medicaid.

On November 2, 2016, NYSOH issued an eligibility determination notice based on the information contained in the November 1, 2016 application, stating that you were eligible to receive up to $229.00 per month in advance payments of the premium tax credit and cost-sharing reductions, effective December 1, 2016.

On February 23, 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) On September 22, 2016, you updated your NYSOH account by telephone. You listed an expected yearly income of $14,019.00.

2) You testified, and your account reflects, that you uploaded a copy of your 2015 federal income tax return to your NYSOH account On September 28, 2016.

3) You testified that during November 2016 there was a system defect which prevented you from changing the income information in your NYSOH account.

4) NYSOH records reflect that there was a defect beginning on October 6, 2016 "for no income details" which was resolved on November 28, 2016.

5) However, NYSOH records reflect that on November 1, 2016 you updated your NYSOH account by telephone. You listed an expected yearly income of $24,688.00.

6) 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.

7) You are seeking insurance for yourself.

8) The application dated November 1, 2016 listed annual household income of $24,688.00, consisting of $21,120.00 you earn from your employment, as well as additional annual income including $415.00 [redacted], $923.00 [redacted], $555.00 [redacted], $3,283.00 [redacted], $5,386.00 re[redacted], and $2,000.00 in other income.

9) The November 1, 2016 application states that you will be taking the following annual deductions on your 2016 tax return: $354.00 Self-Employment tax deduction and $8,640.00 S/E health insurance deduction.

10) Your application states that you live in Richmond County.

11) You testified that you made changes to the income information in your NYSOH account in January 2017.

12) NYSOH records reflect that the user name [redacted] has been utilized to update your account since November 2015.

13) On January 9, 2017, your NYSOH account reflects an update was created by [redacted] which listed an expected yearly income of $24,688.00.

14) On January 17, 2017, your NYSOH account reflects an update was created by [redacted] which listed an expected yearly income of $21,361.00.

15) You testified that you are seeking a redetermination of eligibility regarding the level of your advance premium tax credit and to redetermined eligible for Medicaid.

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 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

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, among other things, have a household modified adjusted gross income 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 Federal Register 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 $229.00 per month, and not Medicaid.

The application that was submitted on November 1, 2016 listed an annual household income of $24,688.00 and the eligibility determination relied upon that information.

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 Richmond County, where the second lowest cost silver plan available for a primary subscriber through NYSOH costs $368.26 per month.

An annual income of $24,688.00 is 209.75% of the 2015 FPL for a one-person household. At 209.75% of the FPL, the expected contribution to the cost of the health insurance premium is 6.76% of income, or $138.97 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 ($368.26 per month) minus your expected contribution ($138.97 per month), which equals $229.29 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $229.00 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 $24,688.00 is 209.75% of the applicable FPL, NYSOH correctly found you to be eligible for cost-sharing reductions.

Similarly, for the purposes of eligibility for Medicaid, $24,688.00 is 207.81% of the 2016 FPL for a one-person household. Therefore, NYSOH correctly found you were not eligible for Medicaid.

Since the November 2, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $229.00 per month in APTC and eligible for cost-sharing reductions, it is correct and is AFFIRMED.

A review of your NYSOH account reflects the following: on September 22, 2016 you updated your NYSOH account by telephone attesting to an expected yearly income of $14,019.00. On November 1, 2016, you updated your NYSOH account by telephone attesting to an expected yearly income of $24,688.00. However, during the hearing, you testified that you did not update your NYSOH application on November 1, 2016.

You also testified that you accessed your NYSOH account and made changes to your household income in January 2017.

NYSOH records reflect that on January 9, 2017, you updated your NYSOH account and attested to an expected yearly income of $24,688.00, and on January 17, 2017, you updated your NYSOH account attesting to an expected yearly income of $21,361.00.

There has been no testimony provided to explain the inconsistencies in the expected yearly income amounts attested to in the applications submitted to NYSOH. Further, your testimony regarding the November 1, 2016 application is contradicted by the evidence. You testified that during November 2016 there was a system defect which prevented you from changing the income information in your NYSOH account. However, NYSOH records reflect that on November 1, 2016 that you updated your NYSOH account by telephone and changed your income information.

Therefore, based on the inconsistencies noted above, it is found that your testimony and applications are not reliable with regard to your expected household earnings, and that there is insufficient evidence to overturn the November 2, 2016 eligibility determination.

Decision

The November 2, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: April 18, 2017

How this Decision Affects Your Eligibility

You remain eligible for up to $229.00 in APTC, and cost-sharing reductions.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace 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 Federal Marketplace. 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 have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

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 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).

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 November 2, 2016 eligibility determination notice is AFFIRMED.

You remain eligible for up to $229.00 in APTC and cost-sharing reductions.

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]

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).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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