



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

Notice of Decision

Decision Date: April 28, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013059

[REDACTED]

Dear [REDACTED]

On February 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 4, 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).

This page intentionally left blank.



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

Decision

Decision Date: April 28, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013059



Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health properly determine that you and your spouse were not eligible for financial assistance, effective December 1, 2016?

Procedural History

On November 3, 2016, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating you were eligible to purchase a qualified health plan at full cost through NYSOH. That determination also stated your spouse was eligible to receive \$0.00 in advance payments of the premium tax credit (APTC).

Also on November 3, 2016, you spoke to NYSOH's Account Review Unit and appealed this determination insofar as you were not eligible to receive APTC and your spouse was not eligible to receive more than \$0.00 in APTC.

On November 4, 2016, NYSOH issued a notice of eligibility determination, based on the November 3, 2016 application, stating you were eligible to purchase a qualified health plan at full cost through NYSOH and your spouse was eligible to receive \$0.00 in APTC, for a limited time. The notice indicated your spouse was eligible for a limited time because NYSOH needed more information to confirm the information in your application. The notice further indicated your household income was \$88,190.00. The notice directed your spouse to submit proof of income by February 1, 2017. This eligibility was effective December 1, 2016.

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).

On November 23, 2016, NYSOH issued an eligibility determination notice, based on a November 22, 2016 systematic eligibility redetermination, stating you were eligible to purchase a qualified health plan at full cost through NYSOH and your spouse was eligible to receive \$0.00 in APTC, effective January 1, 2017. The notice stated your household income was \$79,208.00. The notice further stated your spouse's eligibility for APTC was based on the number of people in his household, his household income, and the cost of plans available in his county. The notice explained that depending on the cost of plans available in your county, your advance premium tax credit might be \$0.

On February 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents. On February 22, 2017 NYSOH received a copy of two bi-weekly paystubs. On April 18, 2017, NYSOH Appeals Unit requested additional documentation. On April 21, 2017, NYSOH received a copy of a 2016 Benefit and Rate Summary for MVP Health Care. The record closed thereafter.

Findings of Fact

A review of the record supports the following findings of fact:

- 1) You testified that you and your spouse expect to file your 2016 taxes with a tax filing status of married filing jointly. You will claim two dependents on that tax return.
- 2) You are seeking insurance for you and your spouse.
- 3) You contacted NYSOH and your application was updated several times on November 3, 2016. Each application listed annual household income of \$88,190.00, consisting of \$47,790.00 you earn from your employment, with a \$9,600.00 health savings account deduction, and \$50,000.00 your spouse receives in income from his business. You testified the income listed for you, \$38,190.00 after deductions, was accurate; however, the income amount listed for your spouse was incorrect. You testified you were confused by the questions asked and you must have made a mistake when you reported your spouse's income.
- 4) Each application update submitted on November 3, 2016 indicated you were enrolled in Employer Sponsored Health Insurance (ESI) as of December 1, 2016 at a cost of \$628.98 monthly. The applications did not indicate your spouse was covered by this plan.

- 5) On November 8, 2016, a copy of a Form 1040 tax return for you and your spouse for the 2015 tax year was uploaded to your NYSOH account. Additionally, two of your bi-weekly paystubs were uploaded.
- 6) You testified you earned significantly more income in 2016 as opposed to 2015, because you were promoted in 2016 and began working full time. Therefore, you testified the 2015 tax return submitted was not an accurate representation of your current income.
- 7) You testified the 2015 tax return submitted was an accurate representation of your spouse's income. You testified the \$26,756.00 listed on line 12 of that return was business income your spouse earned in 2015. You testified his income was similar in 2016.
- 8) You testified you and your spouse also had rental income in 2016. You testified the rental income you and your spouse earned in 2016 was the same amount you earned in 2015 which was represented on the 2015 tax return on line 17 as \$6,835.00. You testified you were unsure if you included this income in your November 3, 2016 updated applications.
- 9) The 2015 tax return and paystubs you and your spouse submitted as proof of 2016 income were verified by NYSOH on November 22, 2016. That day your application was systematically updated to reflect the information contained in this income documentation.
- 10) The systematic application update on November 22, 2016 listed your spouse's income as \$50,000 and reduced it by \$8,982.00, which was the amount of self-employment tax listed on your 2015 tax return; \$1,890.00, plus a \$7,092.00 "self-employment health insurance deduction." This reduced the household income to \$79,208.00.
- 11) Based on the information in the November 22, 2016 updated application, you still did not qualify for financial assistance and your spouse still qualified for \$0.00 in monthly APTC.
- 12) You testified you and your spouse have both been enrolled in comprehensive ESI through your employer since January 1, 2016.
- 13) You testified your ESI is unaffordable and both you and your spouse are seeking financial assistance with health coverage in the form of APTC through NYSOH instead.
- 14) You testified the paychecks uploaded to your account on November 8, 2016, showed the amount of the insurance premium automatically deducted from your biweekly paycheck listed under a deduction for "[REDACTED]".

- 15) Both paychecks uploaded November 8, 2016 included a [REDACTED] deduction in the amount of \$408.57. You testified this amount was deducted biweekly.
- 16) You further testified your health insurance premium increased in 2017 and you submitted two biweekly paystubs with check dates in February 2017 listing Sec. 125 deductions in the amount of \$476.27.
- 17) You submitted a 2016 Benefit and Rate Summary Sheet from MVP Health Care. This document indicates the “current rates” for an individual medical, pharmacy and dental plan was \$408.57.
- 18) Your application indicates you and your spouse live in [REDACTED]

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)).

General Deductions

“Adjusted gross income” means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

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

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).

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 Federal Register 3236, 3237).

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).

Employer-Sponsored Insurance

An employee who may enroll in an employer-sponsored health insurance plan and an individual who may enroll in the plan because of a relationship to the employee are considered eligible for minimum essential coverage as long as the plan "is affordable and provides minimum value" (26 CFR § 1.36B-2(c)(3)(i)).

An eligible employer-sponsored plan is "affordable" if the portion of the annual premium that the employee or related individual must pay for *self-only* coverage does not exceed the required contribution. The required contribution percentage

is 9.66% of the employee's household income for 2016 (26 CFR § 1.36B-2(c)(3)(v), 26 CFR § 1.36B-2T, IRS Rev. Proc. 2014-62).

Legal Analysis

The issue under review is whether NYSOH properly determined you and your spouse were not eligible for financial assistance, effective December 1, 2016.

You updated your application several times on November 3, 2016. Each application update submitted indicated you were enrolled in ESI as of December 1, 2016 at a cost of \$628.98 monthly. The applications did not indicate your spouse was covered by this plan. However, you testified both you and your spouse have been enrolled in an ESI plan through your employer since January 1, 2016. You testified your ESI is unaffordable and both you and your spouse are seeking financial assistance with health coverage in the form of APTC through NYSOH instead.

Pursuant to the above cited regulations, applicants otherwise eligible for minimum essential coverage outside of NYSOH are generally not eligible to receive APTC. ESI is considered minimum essential coverage if the plan "is affordable and provides minimum value." Additionally, this is applicable not only to the employee, but to any individual who may enroll in the plan because of a relationship to the employee.

You submitted a 2016 Benefit and Rate Summary Sheet from MVP Health Care. This document indicates the rate for an individual medical, pharmacy, and dental plan was \$408.57. This document does not indicate whether the stated rates are monthly or bi-weekly.

You testified, and the documentation submitted confirms, you are paid bi-weekly. Paystubs uploaded to your NYSOH account indicate that in 2016 you had \$408.57 deducted from your gross income bi-weekly for insurance premiums. According to the MVP rate sheet provided, the rate for a couple's plan in 2016 was \$817.14, double the amount for an individual plan. Based on this information and your testimony that both you and your spouse were enrolled in an ESI plan through your employer in 2016, it is concluded you and your spouse were enrolled in a couple's ESI plan in 2016 at a monthly rate of \$817.14.

In accordance with the regulations, An ESI will be considered "affordable" if the portion of the annual premium that the employee or related individual must pay for **self-only coverage** does not exceed the required contribution. The required contribution percentage is 9.66% of the employee's household income for 2016.

Although the evidence establishes you and your spouse contribute \$817.14 monthly for your ESI plan premiums, the regulations base a determination of the

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).

affordability of ESI on the cost of an individual plan offered by the employer, regardless of whether you are enrolled in a more expensive plan. According to the evidence, the cost of an individual ESI plan through your employer is \$408.57 monthly, or \$4,902.84 annually. Accordingly, if this amount exceeds 9.66% of your household's income for 2016, your ESI will be considered unaffordable.

As discussed above, the evidence establishes your annual household income for 2016 was \$69,951.00. Additionally, the evidence establishes an individual ESI plan offered by your employer in 2016 costs \$4,902.84 annually. \$4,902.84 is 7.01% of \$69,951.00. Therefore, you are eligible for ESI at a cost of 7.01% of your household's 2016 annual income. This is less than the required contribution of 9.66% under the regulations. Accordingly, your ESI is deemed affordable.

There being no evidence that your ESI plan does not provide "minimum value", the evidence establishes you are eligible for "minimum essential coverage". As such, you are not eligible to receive APTC.

It is noted the November 4, 2016 eligibility determination notice stating you were eligible to purchase a qualified health plan at full cost and your spouse was not able to receive APTC through NYSOH did not indicate the reason you are not eligible to receive APTC. Therefore, the November 4, 2016 eligibility determination notice is MODIFIED to clarify that you and your spouse are not eligible for financial assistance because you are both eligible for affordable minimum essential coverage through your employer.

The subsequent November 23, 2016 eligibility determination is similarly MODIFIED only to clarify that you and your spouse are not eligible for financial assistance because you are both eligible for affordable minimum essential coverage through your employer.

Decision

The November 4, 2016 and November 23, 2016 eligibility determinations are MODIFIED to clarify that you and your spouse are not eligible for financial assistance because you are both eligible for affordable minimum essential coverage through your employer.

Effective Date of this Decision: April 28, 2017

How this Decision Affects Your Eligibility

You and your spouse are not eligible to receive financial assistance because you both are eligible for minimum essential coverage through your employer.

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 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 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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The November 4, 2016 and November 23, 2016 eligibility determinations are MODIFIED to clarify that you and your spouse are not eligible for financial assistance because you are both eligible for affordable minimum essential coverage through your employer.

You and your spouse are not eligible to receive financial assistance because you both are eligible for minimum essential coverage through your employer.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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।

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).

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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.

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).