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

Notice of Decision

Decision Date: May 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015208

[redacted]

Dear [redacted],

On April 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 27, 2017 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015208

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you and your spouse were eligible to purchase a qualified health plan at full cost, effective March 1, 2017?

Procedural History

On January 26, 2017, NYSOH received your and your spouse's application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating that you and your spouse were eligible to enroll in a qualified health plan at full cost.

On January 26, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you and your spouse were not eligible for financial assistance.

On January 27, 2017, NYSOH issued an eligibility determination notice based on the information contained in the January 26, 2017 application, stating you and your spouse were eligible to purchase a qualified health plan at full cost effective March 1, 2017. The notice further stated that you and your spouse were not eligible to receive advance premium tax credits (APTC) because you and your spouse were already enrolled in or eligible for minimum value employer sponsored insurance.

On April 20, 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 up until May 5, 2017 to allow you time to submit supporting documentation.

Also on April 20, 2017, you faxed a letter from [redacted] which stated that the weekly contribution for employer sponsored individual coverage is $11.40. The record was closed that day.

Findings of Fact

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

1) You are appealing your and your spouse's eligibility.

2) The application that was filed on January 25, 2017 listed an annual household income of $48,484.75, consisting of income earned by your spouse. You testified that this amount was incorrect, and that his annual expected income is $46,000.00.

3) You testified that you and your spouse are eligible for and currently enrolled in health insurance through his employer which has a weekly cost of $118.49 for a couple's plan.

4) You provided documentation that an individual plan through your spouse's employer would cost $11.40 weekly.

5) You testified that the insurance through your spouse's employer is unaffordable to you and your spouse.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Advance Payments of the Premium Tax Credit

An APTC is available to a person who is eligible to enroll in a qualified health plan and

1. expects to have a household income between 138% and 400% of the Federal Poverty Line (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 qualified health plan, and

3. is not otherwise eligible for minimum essential coverage except through the individual market (45 CFR § 155.305(f)).

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)).

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 9.69% of the employee's household income for 2017 (26 CFR §1.36B-2(c)(3)(v), 26 CFR §1.36B-2T, IRS Rev. Proc. 2016-24).

Legal Analysis

The issue is whether NYSOH properly determined that you and your spouse were eligible to purchase a qualified health plan at full cost, effective March 1, 2017.

In the eligibility determination notice issued on January 27, 2017, NYSOH denied APTC to you and your spouse because you and your spouse were eligible for or enrolled in health insurance coverage through your spouse's employer.

An employee or a related individual to the employee, who is eligible to enroll in an employer-sponsored health insurance plan that is affordable and provides minimum value, is not eligible for advance premium tax credits through NYSOH.

During the hearing, you testified that you and your spouse are enrolled in employer-sponsored insurance through your spouse's employer. You testified

that the insurance through his employer is unaffordable to you. Employer-sponsored health insurance coverage is considered to be affordable if it costs no more than 9.69% of the household income. NYSOH uses the amount you would pay for self-only coverage through an employer to calculate whether or not a plan is affordable.

The application that was filed on January 25, 2017 listed an annual household income of $48,484.75, which consists of income earned by your spouse. You testified that this amount was incorrect, and that his annual expected income is $46,000.00.

Therefore, your spouse's employer sponsored health insurance coverage would be unaffordable to you if the premium cost associated with the self-only plan cost more than $4,457.40 per year ($46,000.00 x 9.69%).

You provided documentation that if your spouse enrolled in a self only plan through his employer he would pay a weekly cost of $11.40. This results in an annual cost of $592.80 ($11.40 x 52 weeks). Since the annual cost for a self-only plan through your spouse's employer is less than $4,457.40, it is considered affordable by NYSOH.

Since you and your spouse have health insurance coverage through your spouse's employer that costs less than 9.69% of your household income and there is no indication in the record that the coverage does not provide minimum value to you, the January 27, 2017 eligibility determination is correct and is AFFIRMED.

Decision

The January 27, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: May 9, 2017

How this Decision Affects Your Eligibility

You and your spouse are not eligible for financial assistance through NYSOH.

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
  Albany, NY 12211

- By fax: 1-855-900-5557

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).

Summary

The January 27, 2017 eligibility determination is AFFIRMED.

You and your spouse are not eligible for financial assistance through NYSOH.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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 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 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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