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

Notice of Decision

Decision Date: July 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016391

[redacted]

Dear [redacted]

On June 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 25, 2017 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
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Decision

Decision Date: July 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016391

[redacted]

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 and your spouse were eligible to purchase a qualified health plan (QHP) at full cost, effective April 1, 2017?
>
> Did NYSOH properly determine that you and your spouse were not eligible for the Essential Plan?

Procedural History

On January 3, 2017, NY State of Health (NYSOH) received your updated application for health insurance.

On January 4, 2017, NYSOH issued an eligibility determination notice, based on the information contained in the January 3, 2017 application, stating in part that you and your spouse were eligible to enroll in the Essential Plan with a $20.00 monthly premium each, effective February 1, 2017.

Also on January 4, 2017, NYSOH issued a plan enrollment notice, based on your plan selection on January 3, 2017, confirming that you and your spouse were enrolled in an Essential Plan, with a $20.00 monthly premium each and that your coverage would start February 1, 2017.

On February 9, 2017, NYSOH received your updated application for health insurance. That application indicated that you and your family were eligible for employer-sponsored health insurance effective March 1, 2017.

On February 10, 2017, NYSOH issued an eligibility determination notice, based on the information contained in the February 9, 2017 application, stating in part that you and your spouse were eligible to purchase a QHP at full cost beginning March 1, 2017. The notice further stated that you and your spouse were not eligible to receive advance premium tax credits (APTC) because you were already enrolled in or eligible for minimum value employer-sponsored insurance, and you were not eligible for cost-sharing reductions because you were not eligible for APTC. You also did not qualify for the Essential Plan or APTC because you did not provide information about the cost of health coverage offered to you by your employer which is required to see if you qualify for help paying for health coverage.

Also on February 10, 2017, NYSOH issued a disenrollment notice stating that your and your spouse's coverage in your Essential Plan would end February 28, 2017, because both of you were no longer eligible to enroll in that plan.

On February 15, 2017, you uploaded to your NYSOH account, NYSOH-Employer Sponsored Health Insurance Request for Information, form DOH-5106s, for all your family members, as completed by your employer (*see* Documents [redacted].

On February 16, 2017, NYSOH issued an eligibility determination notice stating in part that you and your spouse may be able to enroll in coverage if you qualify for a special enrollment period and, if so, were eligible to enroll in a QHP at full cost through NYSOH, effective March 1, 2017.

On February 24, 2017, the NYSOH-Employer Sponsored Health Insurance Request for Information, form DOH-5106s, were verified by NYSOH and your application for health insurance was updated.

On February 25, 2017, NYSOH issued an eligibility determination notice that stated in part that you and your spouse may be able to enroll in coverage if you qualify for a special enrollment period and, if so, were eligible to enroll in a QHP at full cost through NYSOH, effective April 1, 2017.

On February 28, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the eligibility determination notices insofar as you and your spouse were not eligible for financial assistance because you had access to employer-sponsored health insurance.

On June 16, 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 appealing only your and your spouse's eligibility.

2) According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim four dependents on that tax return.

3) The applications that were filed on February 9, 2017, February 15, 2017 and February 24, 2017 all listed an annual household income of $49,180.00, consisting of $44,980.00 you earn and $4,200.00 your spouse earns from employment. You testified that this amount is accurate.

4) According to your NYSOH account and your testimony, you and your spouse are eligible for health insurance through your employer. You testified and the record reflects that the cost of a family plan covering you and your spouse is $151.67 per month.

5) According to your NYSOH account and your testimony, you and your spouse became eligible for employer-sponsored health insurance on March 1, 2017.

6) You testified that the employer-sponsored health insurance is not affordable in comparison to the Essential Plan in which you and your spouse had a monthly premium of $20.00 each.

7) You testified that you and your spouse presently do not have health insurance.

8) According to your NYSOH account and your testimony, you and your spouse live in [redacted], New York.

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

Applicable Law and Regulations

<u>Advance Payments of the Premium Tax Credit</u>

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)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), N.Y. Soc. Serv. Law § 369-gg(3), 42 USC § 18051).

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

In the eligibility determination notices issued on February 10, 2017, February 16, 2017 and February 25, 2017, NYSOH denied you and your spouse financial assistance in the form of APTC and the Essential Plan because you were both eligible for or enrolled in health insurance coverage through your employer.

An employee or a related individual to the employee, who is eligible to enroll in an employer-sponsored health insurance plan, including having access to enroll in such plan, that is affordable and provides minimum value is not eligible for APTC or to enroll in an Essential Health Plan through NYSOH.

During the hearing, you testified that you and your spouse are eligible for employer-sponsored insurance through your employer. You testified that the insurance through your employer is unaffordable to you and the premium to have coverage under the Essential plan is less expensive and more affordable.

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 your employer to calculate whether or not a plan is affordable.

The updated applications that were filed on February 9, 2017, February 15, 2017 and February 24, 2017 listed an annual household income of $49,180.00. You testified that this amount was accurate.

Therefore, your employer sponsored health insurance coverage would be unaffordable to you if the premium cost associated with the self-only plan cost more than $4,765.54 per year ($49,180.00 x 9.69%).

The record does not contain information as to the cost of a self-only plan. However, according to your NYSOH account and your testimony, the cost of a family coverage plan that would include you and your spouse would be $1,820.04 per year ($151.67 monthly premium x 12 months). Since your annual cost for a family plan covering you and your spouse through your employer is less than $4,765.54, and it is likely that the cost for a self-only plan would cost less, the health plan available through your employer is considered affordable by NYSOH.

Since you and your spouse have health insurance coverage available through your 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 and your spouse, the February 10, 2017, February 16, 2017 and February 25, 2017 eligibility determination notices, to the extent they found you and your spouse eligible to purchase a QHP at full cost, effective March 1, 2017 and April 1, 2017, were correct and are AFFIRMED.

Decision

The February 10, 2017, February 16, 2017 and February 25, 2017 eligibility redetermination notices, to the extent they found you and your spouse eligible to purchase a QHP at full cost, effective March 1, 2017 and April 1, 2017, were correct and are AFFIRMED.

Effective Date of this Decision: July 17, 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 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 February 10, 2017, February 16, 2017 and February 25, 2017 eligibility redetermination notices, to the extent they found you and your spouse eligible to purchase a QHP at full cost, effective March 1, 2017 and April 1, 2017, were correct and are 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:

[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 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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