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

Notice of Decision

Decision Date: October 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020482

[redacted]

Dear [redacted]

On October 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 14, 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: October 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020482

[redacted]

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 were eligible to purchase a qualified health plan at full cost, effective August 1, 2017?

Procedural History

On July 13, 2017, NY State of Health (NYSOH) received your application for health insurance. That day, a preliminary eligibility determination was prepared finding you eligible to enroll in a qualified health plan at full cost.

Also on July 13, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not eligible for financial assistance.

On July 14, 2017, NYSOH issued an eligibility determination notice, based on the information contained in the July 13, 2017 application, stating you were eligible to purchase a qualified health plan at full cost beginning August 1, 2017. The notice further stated that you 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.

On September 29, 2017, you were scheduled to have a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. You requested that day that the hearing be adjourned to a later date; which was granted.

On October 4, 2017, you had an adjourned telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. Under oath, you waived your right to formal notice of the telephone hearing. 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 testified that you intend to file your 2017 tax return with a tax filing status of single and will claim no dependents on that tax return.

2) You are seeking insurance for yourself.

3) The application that was filed on July 13, 2017, listed an annual household income of $23,270.00. You testified that this amount was correct at the time you filed your application.

4) You testified that you are paid weekly and that you make about $447.50 per week before taxes.

5) You testified that you are eligible for and enrolled in health insurance through your employer, which has a monthly cost of $35.00.

6) You testified that the insurance through your employer is unaffordable to you because it has high co-pays associated with your medications and it does not cover certain medical treatments that you need.

7) You testified that you would like to be found eligible for the Essential Plan.

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)).

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)).

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 9.66% of the employee’s household income for 2017 (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 that you were eligible to purchase a qualified health plan at full cost.

In the eligibility determination notice issued on July 14, 2017, NYSOH denied you any financial assistance with health insurance to you because you were 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 that is affordable and provides minimum value, is not eligible for advance premium tax credits or eligible to enroll in an Essential Health Plan through NYSOH.

During the hearing, you testified that you are enrolled in employer-sponsored insurance through your employer. You testified that the insurance through your employer is unaffordable to you because it carries very high co-pays associated with medication and does not cover certain medical treatments that you need. Employer-sponsored health insurance coverage is considered to be affordable if the premiums costs no more than 9.66% of the household income.

The application that was filed on July 13, 2017 listed an annual household income of $23,270.00. You testified that this amount was correct at the time you filed your application.

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 $2,247.88 per year ($23,270.00 x 9.66%).

You provided testimony the self only plan through your employer that you are enrolled in costs you $35.00 a month. This results in an annual cost of $420.00 ($35.00 x 12 months). Since your annual cost in premium payments for a self-only plan through your employer is less than $2,247.88, it is considered affordable by NYSOH.

Therefore, there is no evidence to establish that your employer-sponsored health insurance is unaffordable. While you allege that your employer-sponsored health insurance carries high co-pays and does not cover certain medical treatments, there is no evidence that your contributions to your premium payments exceeds 9.66% of your annual household income. In accordance with the above cited authority, the cost of the employer-sponsored health insurance plan, i.e., your portion of the premium payments, determines whether the employer-sponsored health insurance is considered affordable, not the amount of the co-pays the plan requires.

Since you have health insurance coverage through your employer that costs less than 9.66% of your household income and there is no indication in the record that the coverage does not provide minimum value to you, the July 14, 2017 eligibility determination is correct and is AFFIRMED.

Decision

The July 14, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: October 19, 2017

How this Decision Affects Your Eligibility

You 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

Summary

The July 14, 2017 eligibility determination is AFFIRMED.

You 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।

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 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.

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).