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

Notice of Decision

Decision Date: April 25,2017

NY State of Health Account ID:
Appeal Identification Number: AP000000013869

Dear

On April 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 8, 2016 eligibility redetermination 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 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 25,2017

NY State of Health Account ID:
Appeal Identification Number: AP000000013869

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 ineligible for advance payments of the premium tax credit (APTC) effective January 1, 2017?

Procedural History

According to your NYSOH account, you and your spouse were eligible to share in an amount of up to $451.00 in APTC and were enrolled in a gold-level health plan with a monthly premium of $647.76 after APTC of $451.00 was applied, effective January 1, 2016.

On December 7, 2016, NYSOH issued a preliminary eligibility redetermination stating that you and your spouse were newly eligible to purchase a qualified health plan at full cost, effective January 1, 2017.

Also on December 7, 2016, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination insofar as you and your spouse were no longer eligible for an APTC, effective January 1, 2017.

On December 8, 2016, NYSOH issued an eligibility redetermination notice that was consistent with the December 7, 2016 preliminary redetermination and stated that, effective January 1, 2017, you and your spouse were newly eligible to purchase a qualified health plan at full cost. This notice stated that you and your spouse were no longer eligible to receive APTC or cost-sharing reductions

because APTC were paid to your health insurance company to reduce your and your spouse's premium costs in a prior year and NYSOH were unable to tell if a federal tax return was filed for that year.

On December 15, 2016, NYSOH issued an eligibility redetermination notice, based on your December 14, 2016 updated application, stating that you and your spouse were eligible to purchase a qualified health plan at full cost. This notice stated that you and your spouse were no longer eligible to receive APTC or cost-sharing reductions because APTC were paid to your health insurance company to reduce your and your spouse's premium costs in a prior year and NYSOH were unable to tell if a federal tax return was filed for that year. This eligibility was effective January 1, 2017.

Also on December 15, 2016, NYSOH issued an enrollment notice, based on your December 14, 2016 plan selection, confirming your and your spouse's enrollment in the gold-level plan, at the full monthly premium amount of $1,262.52, effective January 1, 2017.

On April 7, 2017, you and your spouse had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open to May 7, 2017, to allow you and your spouse to submit supporting documents.

On April 13, 2017, you submitted your and your spouse's 2015 IRS Transcript, which was made part of the record as "Appellant's Exhibit A." The record was closed that same day.

Findings of Fact

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

1) According to your NYSOH account, you and your spouse expect to file your taxes using a tax filing status of married filing jointly, and will not claim any dependents on that return.

2) According to your NYSOH account, your annual household income is listed as $38,396.00, consisting of your income of $11,769.00 and your spouse's income of $26,627.00.

3) Your NYSOH account indicates that on December 7, 2016, you renewed your and your spouse's application for financial assistance and were found no longer eligible for APTC as of January 1, 2017. This was because APTC was paid to your and your spouse's health insurance company to reduce your premium costs in a prior year and NYSOH was unable to tell if a federal tax return had been filed for that year.

4) Your NYSOH account reflects that APTC in the amount of $512.00 per month was paid on your and your spouse's behalf in 2015, as stated in the Forms 1095-A for 2015 (*see* Documents [redacted] and [redacted]).

5) You testified that you are seeking reinstatement of your and your spouse's APTC as of January 1, 2017.

6) You testified that your accountant filed an extension before the deadline in April 2016.

7) On April 13, 2017, you submitted a copy of your and your spouse's 2015 IRS Tax Return Transcript for 2015, which reflects that the IRS received your income tax return for that year, and was reconciled by the IRS, on September 5, 2016 (*see* Appellant's Exhibit A).

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

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

Applicable Law and Regulations

Verification of Eligibility for Advance Payments of the Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 200% 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 qualified health plan, 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)).

An applicant is required to attest to their household's projected annual income for purposes of determining their eligibility for APTC (45 CFR § 155.320(c)(3)(ii)(B)). For all individual's whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income or tax return data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must

request additional information from the applicant to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective as of the first day of the month following the date of the notice (45 § 155.310(f), 45 CFR § 155.330(e), (f)(1)(i)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your spouse were ineligible for APTC effective January 1, 2017.

The record reflects that you and your spouse were enrolled in a gold-level plan beginning January 1, 2015 and received $512.00 per month in APTC throughout the year.

On December 8, 2016, NYSOH issued an eligibility determination notice, based on your December 7, 2016 application, stating that you and your spouse were eligible to purchase a full cost qualified health plan through NYSOH, effective January 1, 2017, as NYSOH had received information that APTC had been paid on your and your spouse's behalf for a year in which you and your spouse did not file a tax return.

This was because, also on December 8, 2016, NYSOH received information that you and your spouse had not filed a tax return for 2015. However, this information was erroneous. Although the IRS Tax Return Transcript for 2015 you provided does not indicate whether you filed a timely extension, you credibly testified that your accountant did so on your behalf in April 2016. Additionally, you submitted documentation that reflects that the IRS received your 2015 income tax return on September 5, 2016, three months before the December 8, 2016 eligibility determination (*see* Appellant's Exhibit A).

Since the December 8, 2016 and December 15, 2016 eligibility redetermination notices are no longer supported by the record, those notices must be RESCINDED.

Since the December 8, 2016 eligibility redetermination notice is no longer supported by the record as developed during and after the hearing, your case is RETURNED to NYSOH to rerun your application to ascertain your and your spouse's eligibility for financial assistance with health insurance as of December 8, 2016 and to apply it effective January 1, 2017 for a two-person household with an expected annual income of $38,396.00, for a couple living in [redacted] [redacted].

Decision

The December 8, 2016 and December 15, 2016, eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to rerun your application to ascertain your and your spouse's eligibility for financial assistance with health insurance as of December 8, 2016 and to apply it effective January 1, 2017 for a two-person household with an expected annual income of $38,396.00, for a couple living in [redacted] and to notify you accordingly.

Effective Date of this Decision: April 25,2017

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility for financial assistance with health insurance, effective January 1, 2017.

NYSOH will notify you once this has been completed.

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 December 8, 2016 and December 15, 2016, eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to rerun your application to ascertain your and your spouse's eligibility for financial assistance with health insurance as of December 8, 2016 and to apply it effective January 1, 2017 for a two-person

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household with an expected annual income of $38,396.00, for a couple living in [redacted] and to notify you accordingly.

Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility for financial assistance with health insurance, effective January 1, 2017.

NYSOH will notify you once this has been completed.

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)

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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।

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.

(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.

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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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