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

Notice of Decision

Decision Date: May 03, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014053

[redacted]

Dear [redacted],

On March 29, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 27, 29, and 30, 2016 eligibility redetermination notices.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: May 03, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014053

[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 your household was not eligible for an advance payment of the premium tax credit (APTC), or cost-sharing reductions(CSR), effective January 1, 2017?
>
> Did your health plan properly disenroll your household from your Platinum Level Qualified Health Plan for the first week of February, 2017?

Procedural History

On November 27, 29, and 30, 2016, NYSOH issued notices of eligibility, based on your November 26, 28, and 29, 2016 applications, stating that your household was eligible to purchase a qualified health plan at full cost, effective January 1, 2017. That notice further stated that your household was ineligible for financial assistance because APTC payments were made to your insurance company to reduce your premium costs in a prior year and NYSOH could not tell if you filed a federal tax return for that year.

On December 15, 2016, you spoke to NYSOH's Account Review Unit and appealed those eligibility determinations insofar as your household was ineligible for APTC, effective January 1, 2017.

Also on December 15, 2016, you enrolled your household in a full price platinum level qualified health plan effective January 1, 2017.

On January 24, 2017, NYSOH issued an eligibility redetermination notice stating your household was conditionally eligible for an APTC of up to $981.00 per month for a limited time, you could also receive cost sharing reductions if you enrolled in a silver level qualified health plan effective March 1, 2017. The notice stated more information was required to confirm your income and you were asked to provide proof by April 23, 2017.

Also on January 24, 2017 an enrollment notice was issued confirming your household's enrollment in a platinum level qualified health plan with the application of APTC of $981.00 effective January 1, 2017.

On March 29, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open 15 days for you to provide additional documentation from your health plan showing your disenrollment, and application of APTC. NYSOH Appeals Unit received a 6-page faxed document on March 29, 2017 and has been incorporated in the record as (Appellant's Exhibit 1).

Findings of Fact

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

1) You submitted applications to NYSOH for financial assistance on November 26, 28, and 29, 2016.

2) You testified you had submitted to NYSOH an IRS transcript of your federal tax return for 2015 reflecting that you filed your income tax return.

3) The record shows you have not submitted a copy of your 2015 IRS tax transcript to NYSOH.

4) You testified that you filed for an extension to file your 2015 individual tax return until October, 2016.

5) Your NYSOH account reflects that APTC was paid on your behalf in 2015 and 2016.

6) You testified that you are seeking APTC as of January 1, 2017.

7) Your account indicates your household was eligible for APTC and cost sharing reductions effective March 1, 2017.

8) You testified that your income information in your application was correct.

9) You uploaded copies of your 2015 tax return to your NYSOH account on November 30, 2016 and January 23, 2017.

10) The record does not contain information showing whether your reconciled your APTC on your 2015 tax return.

11) You provided documentation showing your application of APTC from your health plan for your February premium amount (See Appellant's Exhibit 1, pg. 4).

12) You testified you were disenrolled from your platinum level qualified health plan for February, 2017. You then requested only to pay a prorated amount once you had been reinstated by your health plan effective February 5, 2017 (See Appellant's Exhibit 1, pg.1).

Conflicting evidence, if any, was 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 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 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)).

NYSOH may not determine a tax filer eligible for APTC if APTC was paid on the tax filer's behalf in a previous year, and a tax return was not filed for that previous year (45 CFR §155.305(f)(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 individuals, 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 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)).

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)).

Valid Appeals

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your household was not eligible to receive APTC, or CSR, effective January 1, 2017.

The record shows that on November 26, 28, and 29, 2016, you updated the information in your NYSOH account and submitted requests for financial assistance. NYSOH then issued eligibility redetermination notices that in part stated your household was ineligible for financial assistance. Those notices

further stated that this was because you received APTC in the past and NYSOH was unable to tell if you filed your tax return for the prior year.

However, you provided a copy of your 2015 tax return to NYSOH, and testified you provided a transcript showing your income tax return was filed with the IRS. You testified you filed for an extension until October, 2016. While there is record of your providing a copy of your 2015 tax return, there is no record of NYSOH receiving your 2015 IRS tax transcript. Thus, NYSOH is unable to determine whether you qualified for APTC and cost sharing reductions at the time of your application for the 2017 coverage year.

Since there is insufficient information in the record to determine whether you filed your 2015 tax return, and whether you reconciled the APTC you received for 2015 on that return, the November 27, 29, and 30, 2016 eligibility determination notices finding your household eligible to purchase a qualified health plan at full cost and ineligible for APTC or cost-sharing reductions effective January 1, 2017, are AFFIRMED.

The second issue is whether your health plan properly disenrolled your household from your platinum level qualified health plan for the first week of February, 2017.

During your telephone hearing, you testified you were seeking to only be responsible for a prorated premium amount for the month of February, 2017, after being disenrolled for the first week.

This issue relates to payment of premium responsibility which is not an issue that the NYSOH Appeals Unit is authorized to address. Therefore, we must DISMISS your appeal on this issue.

Decision

The November 27, 29, and 30, 2016 eligibility redetermination notices are AFFIRMED.

Your appeal to request a prorated premium responsibility for the month of February, 2017 is DISMISSED.

Effective Date of this Decision: May 03, 2017

How this Decision Affects Your Eligibility

Your household was ineligible for APTC and CSR effective January 1, 2017.

This decision has no effect on subsequent determinations if they found your household now eligible to receive APTC and CSR.

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 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 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 November 27, 29, and 30, 2016 eligibility redetermination notices are AFFIRMED.

Your appeal to request a prorated premium responsibility for the month of February, 2017 is DISMISSED.

Your household was ineligible for APTC and CSR effective January 1, 2017.

This decision has no effect on subsequent determinations if they found your household now eligible to receive APTC and CSR.

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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