



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

## Notice of Decision

Decision Date: May 19, 2017

NY State of Health Account ID [REDACTED]  
Appeal Identification Number: AP000000014844

[REDACTED]

Dear [REDACTED],

On April 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 6, 2017 eligibility and enrollment confirmation 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 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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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: May 19, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014844

[REDACTED]

## Issue

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

Did NY State of Health (NYSOH) improperly withhold an advance payment of the premium tax credit (APTC) for the month of January 2017, for which you were eligible?

## Procedural History

On December 13, 2016, you submitted an application for financial assistance.

On December 14, 2016, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your two oldest children were eligible to receive up to \$939.00 in APTC, as well as cost-sharing reductions, effective January 1, 2017.

Also on December 14, 2016, NYSOH issued a notice confirming you, your spouse and two oldest children's enrollment in qualified health plan with APTC, effective January 1, 2017.

On January 5, 2017, a non-financial application was submitted to NYSOH.

On January 6, 2017, NYSOH issued an eligibility determination notice stating that you, your spouse, and your three children were newly eligible to purchase a qualified health plan at full cost, effective February 1, 2017.

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Also on January 6, 2017, NYSOH issued an enrollment confirmation notice stating that you, your spouse, and your two oldest children were enrolled in a qualified health plan, effective January 1, 2017 with no APTC applied to your premium.

On January 13, 2017, you updated your application, once again requesting financial assistance.

Also on January 13, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your APTC for the month of January 2017.

On January 14, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your two oldest children were eligible to receive up to \$939.00 in APTC, effective February 1, 2017.

Also on January 14, 2017, NYSOH issued an enrollment confirmation notice stating that you, your spouse and two oldest children were enrolled in a qualified health plan with \$939.00 of APTC applied to your premium, effective February 1, 2017.

On April 7, 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 testified that you, your spouse, and your two oldest children were determined eligible for APTC in the amount of \$939.00 for the month of January 2017.
- 2) NYSOH records reflect that on January 5, 2017, a non-financial application was submitted to your NYSOH account with the user name [REDACTED]
- 3) You testified that you did not submit or authorize anyone to submit a non-financial application to NYSOH on January 5, 2017. You testified that you had no knowledge of the user name "[REDACTED]"
- 4) You testified that you received your APTC in the amount of \$939.00 for the month of January 2017.

- 5) You testified that you received a notice dated January 6, 2017 from NYSOH stating that you, your spouse, and your two oldest children were not eligible for APTC in the month of January 2017.
- 6) You testified that thereafter you contacted NYSOH and were advised that the APTC you received in January 2017 could be retroactively terminated.
- 7) The January 6, 2017 eligibility determination notice issued by NYSOH stated that you, your spouse and two oldest children were eligible to purchase a qualified health plan at full cost, effective February 1, 2017. The section of this notice which was entitled "How we made our decision" was blank.
- 8) The January 6, 2017 enrollment confirmation notice stated that you, your spouse, and your two oldest children were enrolled in a qualified health plan, effective January 1, 2017 with no APTC applied to your premium.
- 9) On January 13, 2017, you updated your application for financial assistance.
- 10) You testified that you received your APTC in February 2017 and that you are not appealing your eligibility for APTC for February 2017.
- 11) You testified that you are seeking to verify that you were eligible for APTC in January 2017 and that your APTC will not be retroactively terminated for January 2017.

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

Advance payments of the premium tax credit (APTC) are generally available to individuals who are eligible to enroll in a qualified health plan and (1) expect to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expect 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) are 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)).

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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 improperly withheld an advance payment of the premium tax credit (APTC) for the month of January 2017, for which you were eligible.

In the eligibility determination issued on December 14, 2016, you were advised that you, your spouse, and your two oldest children were enrolled in a qualified health plan with APTC, effective January 1, 2017. On the same date, NYSOH issued a notice confirming you, your spouse and two oldest children's enrollment in qualified health plan with APTC, effective January 1, 2017.

On January 5, 2017, a non-financial application was submitted to your NYSOH account with the user name [REDACTED]."

You credibly testified that you did not submit or authorize anyone to submit a non-financial application to NYSOH on January 5, 2017 with the user name "[REDACTED]," and that you had no knowledge of the user name "[REDACTED]."

Regardless of whether you authorized the change to your application, the change was made on January 5, 2017. Therefore, NYSOH was obliged to effectuate that change no earlier than February 1, 2017, as noted in the eligibility determination notice issued on January 6, 2017.

Therefore, the January 6, 2017 enrollment confirmation notice must be MODIFIED to clarify that although your family enrollment in your health plan was effective January 1, 2017, the change in your receipt of APTC would not have gone into effect until February 1, 2017, the first day of the immediately following month.

Since you corrected your application to once again request financial assistance, and your APTC resumed on February 1, 2017, there should have been no gap in your receipt of APTC.

You testified that you received your APTC in January 2017 but that a representative from NYSOH advised you that the APTC you received in January 2017 could be retroactively terminated. You also testified that you are seeking to verify that you were eligible for APTC in January 2017. Therefore, to confirm your eligibility for and correct receipt of APTC, your case is being RETURNED to

NYSOH to verify that you, your spouse, and your two oldest children properly received APTC for the month of January 2017.

## **Decision**

The January 6, 2017 enrollment confirmation notice is MODIFIED to clarify that although your family enrollment in your health plan was effective January 1, 2017, the change in your receipt of APTC would not have gone into effect until February 1, 2017, the first day of the immediately following month.

Your case is being RETURNED to NYSOH to verify that you, your spouse, and your two oldest children properly received APTC for the month of January 2017.

**Effective Date of this Decision:** May 19, 2017

## **How this Decision Affects Your Eligibility**

Your case is being RETURNED to NYSOH to verify that you, your spouse, and your two oldest children properly received APTC for the month of January 2017.

## **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

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).

- 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 January 6, 2017 enrollment confirmation notice is MODIFIED to clarify that although your family enrollment in your health plan was effective January 1, 2017, the change in your receipt of APTC would not have gone into effect until February 1, 2017, the first day of the immediately following month.

Your case is being RETURNED to NYSOH to verify that you, your spouse, and your two oldest children properly received APTC for the month of January 2017.

### **Legal Authority**

We are issuing this determination in accordance with 45 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).



**A Copy of this Decision Has Been Provided To:**



## 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 مجاناً.

### বাংলা (Bengali)

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).

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&tumi ama wo obi a okyerE 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.

### **שׂוֹדֵשׁ (Yiddish)**

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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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