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

Notice of Decision

Decision Date: July 03, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015915

[redacted]

Dear [redacted],

On June 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 27, 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 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: July 03, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015915

[redacted]

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 eligible to purchase a qualified health plan at full cost through NYSOH and not eligible for advanced payments of the premium tax credit (APTC) or cost-sharing reductions, effective May 1, 2017?

Procedural History

On January 24, 2017, NYSOH received your and your spouse's application for financial assistance.

On January 25, 2017, NYSOH issued an eligibility determination notice based on your last application stating you and your spouse were eligible to receive APTC of up to $710.00 per month and eligible for cost sharing reductions if you enrolled in a Silver level qualified health plan, effective March 1, 2017. The notice stated the household income listed in your application was $34,694.00.

Also on January 25, 2017, an enrollment notice was issued confirming your and your spouse's enrollment in a silver level qualified health plan for a cost of $453.14 per month starting March 1, 2017.

On January 25, 2017, NYSOH redetermined your and your spouse's eligibility for financial assistance.

On January 26, 2017, NYSOH issued an eligibility determination notice stating you and your spouse were eligible to enroll in the Essential Plan for a cost of $0.00 per month starting March 1, 2017. The notice stated you no longer qualified for APTC with cost sharing reductions effective February 28, 2017. The notice stated the household income listed in your application was $22,932.00.

Also on January 26, 2017 an enrollment notice was issued confirming your and your spouse's enrollment on January 25, 2017 in an Essential Plan 2 with a $0.00 per month premium effective date of March 1, 2017.

On February 16, 2017, you contacted NYSOH's Account Review Unit and appealed the January 26, 2017, eligibility determination notice, requesting that you and your spouse be found eligible for APTC and cost sharing reductions and remain enrolled in a qualified health plan March 1, 2017.

On March 27, 2017, NYSOH received your updated application for health insurance.

On March 28, 2017, based on your last application stating you and your spouse were eligible to purchase a qualified health plan at full cost starting May 1, 2016. The notice stated you were not eligible for a tax credit and income-based cost sharing reductions because information was missing about your taxes.

On March 28, 2017, NYSOH issued an enrollment notice stating you and your spouse's coverage with the Essential Plan 2, would end effective April 30, 2017.

On June 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you testified you were now appealing the March 28, 2017, determination notice stating you and your spouse were eligible to purchase a qualified health plan at full cost because NYSOH had determined it was missing information regarding your taxes. The record was developed during the hearing and left open fifteen days for you to provide a copy of your 2015 IRS Tax Transcript as the file in your account could not be accessed during your hearing.

On June 6, 2017, NYSOH Appeal's Unit received a ten-page fax with your 2015 IRS tax transcript. (See Appellant's Exhibit 1). See also Documents [redacted] uploaded on June 5, 2017.

Findings of Fact

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

1) You are seeking that you and your spouse be found eligible for advance premium tax credits and cost sharing reductions and to be allowed to enroll in a qualified health plan.

2) You testified at your hearing you were now appealing the March 28, 2017, determination stating you and your spouse were eligible to purchase a qualified health plan at full cost because NYSOH had determined it was missing information regarding your taxes.

3) Your NYSOH account reflects that APTC was paid on your behalf in 2015.

4) Your NYSOH account reflects a response code from state and federal data sources shows the IRS did not receive reconciled advance premium tax credits which were paid on your behalf.

5) You testified that your 2015 tax return was filed late. You were granted an extension to file until October, 2016.

6) On June 6, 2017, you submitted a ten-page fax with your 2015 IRS tax transcript. (See Appellant's Exhibit [redacted]. See also Documents [redacted] uploaded on June 5, 2017.

7) Your 2015 IRS tax transcript shows you filed a tax return on October 6, 2016. (See Appellant's Exhibit [redacted],

8) You testified you believe you reconciled your advance premium tax credits received in 2015.

9) You testified that you both anticipate filing your 2017 tax return as married filing jointly.

10) You testified your expected annual household income for 2017 is $34,694.00.

11) You reside in [redacted], NY.

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 authorize APTC when it was paid on behalf of the tax filer or it's spouse, for a year which the tax data would be utilized for verification of household income and size, and that tax filer and his spouse did not file a tax return for that 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 CFR § 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)).

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 through NYSOH and not eligible for APTC or cost-sharing reductions, effective May 1, 2017.

On January 25, 2017, an application was submitted and you and your spouse were found eligible for the Essential Plan at $0.00 per month premium responsibility effective March 1, 2017. You were both enrolled in an Essential Plan 2 with a start date of March 1, 2017.

On March 27, 2017, NYSOH received your household's updated application for financial assistance. On March 28, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were both eligible to purchase a qualified health plan at full cost through NYSOH, effective May 1, 2017, and ineligible to receive APTC or cost-sharing reductions. This was because APTC was paid to your health insurance company on your behalf in a prior year and NYSOH could not ascertain if a federal tax return was filed for that year.

As a result of this eligibility determination, you and your spouse were disenrolled from your Essential Plan as of April 30, 2017.

If NYSOH is unable to obtain information that a prior year's tax return has been filed, NYSOH may not determine a tax filer eligible for APTC, if APTC was paid on that tax filer's behalf in a previous year.

You testified that you obtained an extension on your 2015 tax return until October 15, 2016. You further testified and provided a copy of your 2015 IRS tax transcript showing your tax return was officially filed on October 6, 2016. (See Appellant's Exhibit [redacted]

Therefore, at the time of your and your spouse's March 27, 2017, application and resulting determination you had in fact filed your 2015 tax return and the data sources NYSOH had relied on to make its determination were incorrect.

Since the March 28, 2017 eligibility determination notice is no longer supported by the record and it is RESCINDED, your case is RETURNED to NYSOH to rerun your and your spouse's application to ascertain your eligibility for financial assistance with health insurance as of May 01, 2016 for a two-person household with an expected annual household income of $34,694.00, for a couple seeking insurance in [redacted]. NYSOH is directed to refer to Appellant's Exhibit [redacted] and [redacted] uploaded on January 5, 2017, for verification you filed your 2015 tax return. NYSOH is also directed to evaluate your and your spouse's eligibility for a special enrollment period as of your March 27, 2017 application.

Decision

The March 28, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to rerun your and your spouse's application to ascertain your eligibility for financial assistance with health insurance as of May 1, 2016 for a two-person household with an expected annual household income of $34,694.00, for a couple seeking insurance in [redacted]. NYSOH is directed to refer to Appellant's Exhibit [redacted] and [redacted] uploaded on January 5, 2017, for verification you filed your 2015 tax return. NYSOH is also directed to evaluate your and your spouse's eligibility for a special enrollment period as of your March 27, 2017 application.

Effective Date of this Decision: July 03, 2017

How this Decision Affects Your Eligibility

You and your spouse will receive a new eligibility determination notice reflecting your eligibility for financial assistance as of May 1, 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
- 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 March 28, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to rerun your and your spouse's application to ascertain your eligibility for financial assistance with health insurance as of May 1, 2016 for a two-person household with an expected annual household income of $34,694.00, for a couple seeking insurance in [redacted]. NYSOH is directed to refer to Appellant's Exhibit [redacted] and [redacted] uploaded on January 5, 2017, for verification you filed your 2015 tax return. NYSOH is also directed to evaluate your and your spouse's eligibility for a special enrollment period as of your March 27, 2017 application.

You and your spouse will receive a new eligibility determination notice reflecting your eligibility for financial assistance as of May 1, 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:

[redacted]

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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 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.

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