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

Notice of Decision

Decision Date: August 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016407

[redacted]

Dear [redacted]

On June 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 19, 2017, and March 10, 2017, eligibility determination 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: August 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016407

[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 February 1, 2017?

Procedural History

On October 3, 2016, you updated your application for financial assistance with your health insurance. That day, a preliminary eligibility determination was prepared stating that you were eligible to enroll in the Essential Plan for a limited time.

On October 5, 2016, NYSOH issued an enrollment notice confirming your enrollment in the Essential Plan 1 on October 3, 2016, effective November 1, 2016.

On October 9, 2016, NYSOH issued an eligibility determination notice based on your October 3, 2016 application stating you were eligible to enroll in the Essential Plan for a limited time, effective November 1, 2016. The notice asked you to provide proof of your income by January 1, 2017.

NYSOH did not receive the requested income documentation by January 1, 2017.

On January 7, 2017, NYSOH redetermined your eligibility for financial assistance.

On January 8, 2017, NYSOH issued an eligibility determination notice stating you were newly eligible to purchase a qualified health plan at full cost, effective February 1, 2017. The notice stated this was because NYSOH did not receive the income documentation needed to verify the income listed in your application.

Also on January 8, 2017, NYSOH issued a cancellation notice stating your enrollment in the Essential Plan would end January 31, 2017. The notice stated this was because you were no longer eligible to enroll in the Essential Plan.

On January 18, 2017, NYSOH received your updated application for financial assistance.

On January 19, 2017, NYSOH issued a notice stating you were eligible to purchase a qualified health plan at full cost, effective February 1, 2017. The notice stated you were not eligible to receive a tax credit and cost sharing reductions because APTC was paid to your health insurance company to reduce your premium costs in a prior year and NYSOH could not ascertain if a federal tax return was filed for that year.

On March 1, 2017, you spoke to NYSOH's Account Review Unit and appealed this determination insofar as you were found ineligible for APTC and cost sharing reductions.

On March 9, 2017, NYSOH received your updated application for financial assistance.

On March 10, 2017, NYSOH issued an eligibility determination notice stating you were eligible to purchase a qualified health plan at full cost, effective April 1, 2017. The notice stated you were not eligible to receive a tax credit and cost sharing reductions because APTC was paid to your health insurance company to reduce your premium costs in a prior year and NYSOH could not ascertain if a federal tax return was filed for that year.

On June 8, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for thirty days to allow you time to submit supporting documentation, specifically, the Hearing Officer requested that you submit your 2015 IRS tax transcript.

On July 5, 2017, you requested an additional 30 days to provide your 2015 IRS tax transcript.

On August 3, 2017, NYSOH received a seven-page fax with your 2015 IRS tax transcript it was incorporated into the record as Appellant's Exhibit 1 and the record was closed.

Findings of Fact

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

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

2) 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.

3) You testified that your 2015 tax return was filed late. You were granted an extension to file.

4) On August 3, 2017, you submitted a copy of your 2015 IRS tax transcript (See Appellant's Exhibit 1).

5) Your 2015 IRS tax transcript shows you filed a tax return for 2015 on February 10, 2017. (See Appellant's Exhibit 1, pg. 1).

6) You testified that you anticipate filing your 2016 and 2017 tax returns as single.

7) Your January 18, 2017 application attested to having an annual expected household income for 2017 of $27,000.00. You testified that you cannot tell if that would be accurate due to your self-employment. You testified it could be less, approximately $26,000.00.

8) You provided an updated application on March 9, 2017 with an attested household income amount of $26,408.00. You testified this was correct.

9) You testified and provided a letter to NYSOH that you could not afford to enroll in a full cost qualified health plan due to your income.

10) 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

<u>Verification of Eligibility for Advance Payments of the Premium Tax Credit</u>

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 § 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 were eligible to purchase a qualified health plan at full cost through NYSOH and not eligible for APTC or cost-sharing reductions, effective February 1, 2017.

On January 18, 2017, NYSOH received your household's application for financial assistance for 2017. On January 19, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective February 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.

Your NYSOH account further indicates it received data from federal and state sources that APTC was paid on your behalf but was not showing as having been reconciled.

You testified that you obtained an extension on your 2015 tax return.

At the time of your January 18, 2017 application, NYSOH had not received information from the IRS that your household's tax return for 2015 had been properly filed and reconciled. 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 the tax filer's behalf in a previous year.

Although you testified you filed your 2015 tax return, the Hearing Officer requested that you submit a copy of your 2015 IRS tax transcript and left the record open for thirty days to allow you to submit this documentation. An extension was granted for an additional 30 days.

On August 3, 2017, NYSOH received a seven-page fax with your 2015 IRS tax transcript. The transcript shows you filed your 2015 tax return on February 10, 2017 (See Appellant's Exhibit 1, pg. 1).

Therefore, at the time of your January 18, 2017, application and resulting determination you had not in fact filed your 2015 tax return and the data sources NYSOH had relied on to make its determination were correct. Therefore, the January 19, 2017 eligibility determination notice was proper and is AFFIRMED.

However, you applied with an additional updated application on March 9, 2017. The response received by NYSOH was the same response received previously regarding NYSOH's inability to obtain information that a prior year's tax return

was filed, or that APTC was reconciled on that return. But, the record now shows that you had in fact filed your 2015 tax return on February 10, 2017.

Since the March 10, 2017, eligibility determination notice is no longer supported by the record as developed by your telephone hearing and submission after the hearing and is RESCINDED, your case is RETURNED to NYSOH to rerun your application to ascertain your eligibility for financial assistance with health insurance as of March 9, 2017, for a one-person household with an expected annual household income of $26,408.00, for an individual residing in [redacted]. NYSOH is directed to refer to [redacted] for verification you filed your 2015 tax return.

Decision

The January 19, 2017 eligibility determination notice is AFFIRMED.

The March 10, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to rerun your application to ascertain your eligibility for financial assistance with health insurance as of March 9, 2017, for a one-person household with an expected annual household income of $26,408.00, for an individual residing in [redacted] NYSOH is directed to refer to [redacted] for verification you filed your 2015 tax return.

Effective Date of this Decision: August 9, 2017

How this Decision Affects Your Eligibility

NYSOH properly determined that you were not eligible for APTC and cost-sharing reductions at the time of your January 18, 2017 application.

You will receive a new eligibility determination notice reflecting your eligibility for financial assistance as of March 9, 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 January 19, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined that you were not eligible for APTC and cost-sharing reductions at the time of your January 18, 2017 application.

The March 10, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to rerun your application to ascertain your eligibility for financial assistance with health insurance as of March 9, 2017, for a one-person household with an expected annual household income of $26,408.00, for an individual residing in [redacted]. NYSOH is directed to refer to [redacted] for verification you filed your 2015 tax return.

You will receive a new eligibility determination notice reflecting your eligibility for financial assistance as of March 9, 2017.

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.

□□□□□ (Bengali)

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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)

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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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