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

Notice of Decision

Decision Date: March 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025553

[redacted]

Dear [redacted],

On February 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 9, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: March 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025553

[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 were not eligible for advance payments of the premium tax credit (APTC) and cost-sharing reductions, effective January 1, 2018?

Procedural History

On December 8, 2017, you applied for health insurance and financial assistance through NYSOH.

That day, a preliminary eligibility determination was prepared stating that you were eligible to purchase a qualified health plan at full cost, effective January 1, 2018.

Also on December 8, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you were not eligible for financial assistance.

On December 9, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective January 1, 2018. The notice stated that you were ineligible for financial assistance because APTC payments were made to your health 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. That notice also stated that you were

not eligible for the Essential Plan or Medicaid because you did not meet the income limits or other eligibility standards for those programs.

Also on December 9, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a qualified health plan, effective January 1, 2018.

On February 3, 2018, NYSOH issued a disenrollment notice stating that your enrollment in a qualified health plan would end on January 1, 2018, because you did not pay your insurance bill by the payment deadline.

On February 13, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to March 13, 2018, to allow you time to submit supporting documents.

On February 2, 2018, NYSOH received your supporting documents by upload. The documents were made part of the record as Appellant's Exhibit #1.

On February 28, 2018, NYSOH received supporting documents by upload. The documents were made part of the record as Appellant's Exhibit #2.

On March 6, 2018, NYSOH received supporting documents by upload. The documents were made part of the record as Appellant's Exhibit #3.

As of March 13, 2018, the Appeals Unit did not receive any further documentation, and no further documentation was viewable in your NYSOH account. The record was closed that day.

Findings of Fact

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

1) According to your NYSOH account, you expect to file your 2018 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You submitted an application to NYSOH for financial assistance on December 8, 2017.

3) You testified that you file your tax returns electronically.

4) You testified that you filed an amended tax return in 2016, and that you probably requested an extension.

5) You testified that you have received APTC since 2014, and that you have filed and reconciled your taxes each year.

6) You testified that you were advised that Form 8962 was the issue with your 2016 taxes.

7) You submitted your 2016 Form 8962 on February 2, 2018 (*see* Document [redacted]; (*see* Appellant's Exhibit #1). The form reflects that your net premium tax credit was $276.00 (*id.*).

8) You submitted your 2016 Account Transcript from the IRS on February 28, 2018 (*see* Document [redacted]; Appellant's Exhibit #2). The one-page document indicates that you requested an extension to file your tax return on April 15, 2017, that you filed your 2016 tax return on August 28, 2017, and filed an amended return on December 4, 2017. The transcript states that a credit in the amount of $276.00 was transferred out to [redacted] on April 15, 2017 (*id.*).

9) You submitted your 2014 Account transcript from the IRS on March 6, 2018 (*see* Document [redacted]; Appellant's Exhibit #3). The one-page document indicates that you filed your 2014 tax return on December 4, 2017 (*id.*).

10) You testified that you are seeking financial assistance as of January 1, 2018.

11) The application that was submitted on December 8, 2017 lists an annual expected household income of $24,296.00. You testified that you expect to earn around $24,000.00 in 2018.

12) Your application states that you live in New York County, 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 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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for APTC or cost-sharing reductions, effective January 1, 2018.

On December 8, 2017, NYSOH received your application for financial assistance. On December 9, 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 January 1, 2018, 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 and properly reconciled for that year.

You testified that you filed an amended tax return in 2016, and that you probably requested an extension. You testified that you have received APTC since 2014, and that you have filed and reconciled your taxes each year.

At the time of your December 8, 2017 application, NYSOH had not received information from the IRS that your household's tax returns for 2014 and 2016 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.

You submitted a copy of your 2016 Form 8962, as well as your Account Transcripts for 2014 and 2016. The 2016 Form 8962 reflects that your net premium tax credit was $276.00. Your 2016 IRS Account Transcript indicates that you requested an extension to file your tax return on April 15, 2017, that you filed your 2016 tax return on August 28, 2017, and filed an amended return on December 4, 2017. The transcript states that a credit in the amount of $276.00 was transferred out to [redacted] on April 15, 2017. Since both the 2016 Form 8962 and 2016 Account Transcript indicate that you had a credit of $276.00 in APTC that year, this documentation corroborates your testimony that you reconciled APTC properly in 2016.

Furthermore, your 2014 IRS Account transcript confirms that you filed your 2014 taxes on December 4, 2017.

Since the December 9, 2017 eligibility determination notice was correct when made, but is no longer supported by the developed record, it must be RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 8, 2017, with an annual expected household income of $24,296.00 for a household size of one, for an individual residing in New York County, and to confirm that you have filed your 2014 tax return and that you have appropriately filed and reconciled APTC on your 2016 tax return.

Decision

The December 9, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 8, 2017, with an annual expected household income of $24,296.00 for a household size of one, for an individual residing in New York County, and to confirm that you have filed your 2014 tax return and that you have appropriately filed and reconciled APTC on your 2016 tax return.

Effective Date of this Decision: March 21, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to redetermine your eligibility based on the completed record and the parameters noted above. NYSOH will issue an eligibility determination notice based thereon.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 9, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 8, 2017, with an annual expected household income of $24,296.00 for a household size of one, for an individual residing in New York County, and to confirm that you have filed your 2014 tax return and that you have appropriately filed and reconciled APTC on your 2016 tax return.

This is not a final determination of your eligibility for financial assitance.

Your case is being sent back to redetermine your eligibility based on the completed record and the parameters noted above. NYSOH will issue an eligibility determination notice based thereon.

Legal Authority

We are sending you this notice 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]

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।

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).

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.

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).