



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

Notice of Decision

Decision Date: May 8, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000026496



Dear [REDACTED]

On May 3, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 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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NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000026496



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 eligible to purchase a qualified health plan at full cost through NYSOH and ineligible for advanced payments of the premium tax credit (APTC) or cost-sharing reductions, effective January 1, 2018?

Procedural History

On November 26, 2017, you updated your application for financial assistance with health insurance.

On November 27, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective January 1, 2018. The notice stated that you were not eligible to receive APTC or cost-sharing reductions in part 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 December 29, 2017, you spoke to NYSOH's Account Review Unit and appealed this determination insofar as you were found ineligible for APTC.

On May 3, 2018, 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.

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Findings of Fact

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

- 1) You testified that you are seeking APTC for yourself.
- 2) You testified, and your NYSOH account reflects, that APTC was paid on your behalf in 2016.
- 3) On April 4, 2018 the first page of your IRS tax transcript for your 2016 tax return was uploaded to your NYSOH account. This transcript indicates that your 2016 tax return was received by the IRS on April 15, 2017 and that you filed form 1040EZ.
- 4) You testified that you file your tax returns as single and do not claim any dependents.
- 5) You testified that you plan to file a tax return for 2018.
- 6) You testified that you did not reconcile your APTC on your 2016 tax return when you initially filed this return.
- 7) You testified that you are working with a new accountant in order to correct your 2016 tax return and reconcile your APTC for 2016, however, you have not yet filed your amended 2016 tax return.
- 8) During the hearing, you testified that you have had a change in circumstances, and are no longer working.

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

Generally, NYSOH must conduct annual eligibility redeterminations for qualified individuals who are seeking financial assistance through insurance affordability programs for the upcoming year, such as tax credits and cost-sharing reductions, Medicaid, or Child Health Plus. In such cases, NYSOH is required to request that the qualified individual provide updated income and family size information for use in an eligibility redetermination for the upcoming year (see 45 CFR § 155.335(a) and (b)).

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)).

People who use APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

You must file Form 1040A or 1040 to claim the premium tax credit (IRS Instructions Form 1040-EZ, published December 13, 2016).

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)).

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 in order 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)).

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 January 1, 2018.

On November 26, 2017, NYSOH received your application for financial assistance for 2018. On November 27, 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 for that year.

At the time of your November 26, 2017 application, NYSOH had not received information from the IRS that your tax return for 2016 has been properly filed or your 2016 APTC reconciled. If NYSOH is unable to obtain information that a prior year's tax return has been filed or APTC reconciled, NYSOH may not determine a tax filer eligible for APTC, if APTC was paid on the tax filer's behalf in a previous tax year.

You submitted the first page of your IRS tax transcript for your 2016 tax return which shows that on April 15, 2017 the IRS received your Form 1040EZ.

You testified that at the time of your initial filing, you had not reconciled your 2016 APTC, which is reconciled on Form 8962. Additionally, in order to reconcile APTC, an individual must file their tax return using Form 1040A or Form 1040. APTC cannot be reconciled on Form 1040EZ.

You testified that you have not yet filed an amended tax return for 2016 reconciling your APTC, although you have reached out to an accountant who is assisting you with this process.

As you received APTC in 2016 and a tax return reconciling your APTC had not been received by the IRS at the time of your November 26, 2017 application, NYSOH properly determined that you were eligible to purchase a qualified health plan at full cost through NYSOH, and ineligible to receive APTC or cost-sharing reductions.

Therefore, the November 27, 2017 eligibility determination notice is **AFFIRMED**.

During the hearing, you testified that you have had a change in circumstances in that you are no longer working. You must contact NYSOH to update your application to reflect your change in income. You may be required to submit documentation showing your change in income.

Decision

The November 27, 2018 eligibility determination notice is **AFFIRMED**.

Effective Date of this Decision: May 8, 2018

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).

How this Decision Affects Your Eligibility

You remain eligible to purchase a qualified health plan at full cost through NYSOH.

This decision does not affect any subsequent eligibility determinations.

You must contact NYSOH to update your application to reflect your change in income. You may be required to submit documentation showing your change in income.

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

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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, 2018 eligibility determination notice is AFFIRMED.

You remain eligible to purchase a qualified health plan at full cost through NYSOH.

This decision does not affect any subsequent eligibility determinations.

You must contact NYSOH to update your application to reflect your change in income. You may be required to submit documentation showing your change in income.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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 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. y&b&tumi ama wo obi a okyer& 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.

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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