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

Notice of Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013177

[redacted]

Dear [redacted],

On February 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 26, 2016 enrollment confirmation notice, November 3, 2016 eligibility determination notice, and November 10, 2016 enrollment confirmation 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: April 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013177

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Was your appeal of the NY State of Health's (NYSOH) July 26, 2016 enrollment confirmation notice timely, and can it be considered by the Appeals Unit of NYSOH?
>
> Did NYSOH properly determine your Essential Plan coverage became effective no earlier than December 1, 2016, as stated in the November 10, 2016 enrollment confirmation notice?
>
> Did NYSOH properly determine you were not eligible for retroactive Medicaid coverage for the month of June 2016?

Procedural History

On July 25, 2016, an updated application for financial assistance with health insurance was submitted on your behalf.

On July 26, 2016, NYSOH issued a notice of eligibility determination stating you were eligible to enroll in the Essential Plan for a limited time, effective September 1, 2016. The notice directed you to provide proof of your income to confirm your eligibility by October 23, 2016 or you might lose your insurance or receive less help paying for your coverage.

Also on July 26, 2016, NYSOH issued an enrollment confirmation notice stating you were enrolled in an Essential Plan with a September 1, 2016 coverage start date.

On July 30, 2016, NYSOH issued a notice indicating the income documentation you submitted was insufficient to confirm the information in your application. The notice directed you to submit additional proof of your income by October 23, 2016.

On November 3, 2016, NYSOH issued an eligibly determination notice stating you were newly eligible to purchase a qualified health plan at full cost through NYSOH, effective December 1, 2016. The notice indicated you were not eligible for financial assistance because NYSOH had not received the income documentation needed to verify the income listed in your application by the deadline.

Also on November 3, 2016, NYSOH issued a notice denying your request for retroactive Medicaid coverage for the month of June 2016.

On November 4, 2016, NYSOH issued a disenrollment notice stating your coverage through your Essential Plan and your dental plan was terminated, effective November 30, 2016, because you were no longer eligible to remain enrolled in the plan.

NYSOH received your updated application on November 9, 2016. That day a preliminary eligibility determination was prepared finding you eligible to enroll in the Essential Plan, effective December 1, 2016. You spoke to NYSOH's Account Review Unit the same day and appealed insofar as your coverage through your Essential Plan began September 1, 2016 rather than July 1, 2016. You also appealed the November 4, 2016 denial of retroactive Medicaid coverage for the month of June 2016.

On November 10, 2016, NYSOH issued an eligibly determination notice stating you were eligible to enroll in the Essential Plan, for a limited time, effective December 1, 2016. The notice directed you to submit proof of your income by February 7, 2017 or you might lose your insurance or receive less help paying for your coverage.

Also on November 10, 2016, NYSOH issued a notice of enrollment confirmation, based on your November 9, 2016 plan selection, stating you were enrolled in an Essential Plan and a dental plan, effective December 1, 2016.

On February 16, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record held open to March 10, 2017, to allow you to submit supporting documents. No documents were received by the deadline.

Therefore, the record closed on March 10, 2017 and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) You testified you were enrolled in Medicaid through your local department of social services and the coverage through this plan ended either May 31, 2016 or June 30, 2016.

2) You testified you had surgery on [redacted] and you have outstanding medical bills from this time.

3) Your account confirms you submitted an updated application to NYSOH on July 25, 2016 indicating you were seeking help paying for medical bills for the month of June 2016. You were determined eligible for the Essential Plan, for a limited time, and you selected a plan for enrollment the same day.

4) Also on July 25, 2016 a copy of a letter from an employer dated March 16, 2016 was uploaded to your NYSOH account. This letter stated your "primary schedule" had you "set to work 38 hours per week at a rate of $11.50 an hour" ([redacted]). This document was deemed invalid proof of your income because it was too old.

5) NYSOH issued an enrollment notice dated July 26, 2016 confirming your enrollment in your Essential Plan, effective September 1, 2016.

6) You were directed to submit additional proof of your income to confirm your eligibly by October 23, 2016.

7) No additional income documentation was received by NYSOH by the deadline and your Essential Plan coverage was terminated as of November 30, 2016.

8) By notice dated November 3, 2016, NYSOH denied you retroactive Medicaid coverage for the month of June 2016 as requested in your July 25, 2016 application.

9) Your updated application for financial assistance was received by NYSOH on November 9, 2016. You were again determined eligible to enroll in the Essential Plan, for a limited time, pending receipt of income documentation. You selected a plan for enrollment the same

day and your coverage through this plan became effective December 1, 2016.

10) Your appeal was filed November 9, 2016.

11) You appealed the September 1, 2016 start date of your Essential Plan, as provided in the July 26, 2016 enrollment confirmation notice, insofar as the plan was not effective July 1, 2016.

12) You testified you were seeking to have your Essential Plan coverage backdated to July 1, 2016.

13) You also appealed the denial of retroactive Medicaid coverage for the month of June 2016 as provided in the November 3, 2016 eligibility determination notice.

14) Your July 25, 2016 application indicated you intended to file your 2016 tax return with a tax filing status of head of household and you would claim one dependent. The application indicated you did not plan on taking any deductions on your tax return

15) You testified that the income amount listed in your July 25, 2016 application for the month of June 2016, $1,893.67, was accurate.

16) NYSOH was unable to verify the income amount listed in your July 25, 2016 application and you were directed to submit proof of your income to verify that information. NYSOH never received valid proof of your income.

17) You were directed to submit proof of your income for the month of June 2016 to the NYSOH Appeals Unit by March 10, 2017. No documentation was received by that deadline.

18) On March 30, 2017, NYSOH Appeals Unit received a copy of the same March 16, 2016 employer letter uploaded to your account on July 25, 2016, stating your “primary schedule” had you “set to work 38 hours per week at a rate of $11.50 an hour” [redacted]. This document was untimely and, accordingly, was not incorporated into the record and was not considered as evidence on appeal.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the federal Poverty Line (FPL) for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Federal Register 4036).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Legal Analysis

The first issue is whether your appeal of NYSOH's July 26, 2016 enrollment confirmation notice is timely.

Your account confirms you submitted an updated application to NYSOH on July 25, 2016. You were determined conditionally eligible for the Essential Plan and you selected a plan for enrollment the same day. NYSOH issued an enrollment notice dated July 26, 2016 confirming your enrollment in your Essential Plan, effective September 1, 2016. NYSOH directed you to submit proof of your income by October 23, 2016.

According to your account, NYSOH never received valid proof of your income to confirm your eligibility and you were disenrolled from your Essential Plan, effective November 30, 2016. You updated your account on November 9, 2016 and the same day you reenrolled into an Essential Plan for a December 1, 2016 coverage start date. You spoke to NYSOH on November 9, 2016 and you filed a formal appeal of the effective date of your Essential Plan insofar as your coverage began September 1, 2016 and not July 1, 2016.

Pursuant to the above cited regulations, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of the September 1, 2016 coverage start date of your Essential Plan as indicated in the July 26, 2016 enrollment confirmation notice, an appeal should have been filed by September 24, 2016. As discussed above, you did not contact NYSOH until November 9, 2016 to file a formal appeal, which is well beyond 60 days from the July 26, 2016

enrollment confirmation notice at issue. It is further noted that, according to your account, you did not contact NYSOH at all between July 25, 2016 and when you finally filed the appeal on November 9, 2016.

Therefore, there has been no timely appeal of the July 26, 2016 enrollment confirmation notice, and your appeal on the issue of whether your Essential Plan should have become effective earlier than September 1, 2016 is DISMISSED.

The second issue is whether NYSOH properly determined your Essential Plan coverage became effective no earlier than December 1, 2016 as stated in the November 10, 2016 enrollment confirmation notice.

You testified, and your account confirms, you updated your NYSOH application on November 9, 2016. As a result, you were found eligible for the Essential Plan, for a limited time, as of December 1, 2016. You enrolled into a plan the same day.

The date on which enrollment in an Essential Plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

On November 9, 2016, you selected an Essential Plan, so your enrollment properly took effect on the first day of the first month following November; that is, on December 1, 2016. There is no evidence to justify backdating your Essential Plan coverage.

Therefore, the November 10, 2016 enrollment confirmation notice stating your enrollment in the Essential Plan was effective December 1, 2016, is correct and must be AFFIRMED.

The third issue under review is whether NYSOH properly determined you were not eligible for retroactive Medicaid coverage for the month of June 2016.

You are in a two-person household; you file your taxes with a tax filing status of head of household and claim one dependent on your tax return.

You submitted an application for financial assistance on July 25, 2016 and requested help in paying for medical bills for the month of June 2016.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether that initial application resulted in Medicaid going forward. Instead,

an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

You testified you are seeking Medicaid for the month of June 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in June 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the Federal Poverty Line, which is $1,843.00 per month for a two-person household.

Your July 25, 2016 application indicated your monthly income for the month of June 2016 was $1,893.67. You testified this amount was correct; however, NYSOH was unable to verify the accuracy of this information. You failed to submit any valid documentation to substantiate the income information listed in this application. Accordingly, NYSOH Appeals Unit is without sufficient evidence to determine whether you were eligible for retroactive Medicaid coverage for the month of June 2016.

It is noted, however, that even accepting the information listed in your July 2016 application, you would not qualify for retroactive Medicaid coverage for the month of June 2016 because the income amount listed, $1,893.67, was over the allowable income limit of $1,843.00.

Therefore, the November 3, 2016 eligibility determination stating you were not eligible for Medicaid in the month of June 2016, is correct and is AFFIRMED.

Decision

Your appeal of the July 26, 2016 enrollment confirmation notice is untimely and is DISMISSED.

The November 10, 2016 enrollment confirmation notice is AFFIRMED.

The November 3, 2016 eligibility determination is AFFIRMED.

Effective Date of this Decision: April 21, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

Your coverage through your Essential Plan was effective September 1, 2016.

You are not eligible for Medicaid in the month of June 2016.

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 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).

If You Have Questions about this Decision (Customer Service Resources):

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- 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

Your appeal of the July 26, 2016 enrollment confirmation notice is untimely and is DISMISSED.

The November 10, 2016 enrollment confirmation notice is AFFIRMED.

The November 3, 2016 eligibility determination is AFFIRMED.

This decision does not change your eligibility.

Your coverage through your Essential Plan was effective September 1, 2016.

You are not eligible for Medicaid in the month of June 2016.

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.

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 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)

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).