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

Notice of Decision

Decision Date: June 7, 2017

NY State of Health Account ID
Appeal Identification Number: AP000000015036

Dear ,

On April 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 10, 2017 enrollment confirmation notice and 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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DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: June 7, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000015036

Issues

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

> Did NY State of Health (NYSOH) properly determine your enrollment in a qualified health plan was effective no earlier than February 1, 2017?
>
> Did NYSOH properly determine you were not eligible for retroactive Medicaid coverage for the month of December 2016?

Procedural History

On January 9, 2017, NYSOH received your updated application for financial assistance with health insurance.

On January 10, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $147.00 per month in advance payments of the premium tax credit (APTC), effective February 1, 2017.

Also on January 10, 2017, NYSOH issued an enrollment notice, based on your January 9, 2017 plan selection, confirming your enrollment in a qualified health plan (QHP) with APTC applied, effective February 1, 2017.

Additionally, on January 10, 2017, NYSOH issued an eligibility determination notice stating your request for retroactive coverage for the month of December 2016 was denied because the program you were eligible for could not pay for any care you received in the past.

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On January 23, 2017, you spoke to NYSOH's Account Review Unit and appealed the effective date of your QHP, insofar as you were not covered by the plan in December 2016.

On April 18, 2017, 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 allow you to submit supporting documents.

On April 25, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1. The record was then closed.

Findings of Fact

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

1) On December 30, 2016, NYSOH received your updated application for financial assistance with health insurance and you were determined eligible to purchase a QHP at full cost, effective February 1, 2017. The eligibility determination notice indicated you were not eligible for a tax credit because you said you would not be filing a tax return, or were married and filing separately, or you did not file a tax return for an earlier year during which you received APTC. You did not enroll in a QHP at that time.

2) According to your account, you updated your application twice on January 9, 2017 and you were determined eligible to receive $147.00 in APTC, effective February 1, 2017. This eligibly determination was based on your final updated application submitted on January 9, 2017.

3) You testified, and your account confirms, you selected a QHP online the same day. According to your account, your coverage through this plan became effective February 1, 2017.

4) The application indicated you were requesting help paying for medical bills in the month of December 2016. That application listed your household income for the month of December 2016 as $3,200.00. Your account indicates this was a system generated income amount, based on your reported annual income.

5) You testified you have outstanding medical bills from December 2016 which total more than your QHP deductible, and you want your coverage through your QHP backdated to December 1, 2016 to provide coverage for that month.

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6) You also testified you wished to appeal the denial of retroactive Medicaid coverage for the month of December 2016.

7) At the hearing, the issue under appeal was formally amended to include a review of the January 10, 2017 eligibility determination notice denying you retroactive Medicaid coverage for the month of December 2016.

8) You were directed to submit proof of your income for the month of December 2016. On April 25, 2017, NYSOH received the following documentation:

   a. Your biweekly paystub with pay date of December 8, 2016 in the gross amount of $1,458.33 [redacted]).

   b. Your biweekly paystub with pay date of December 23, 2016 in the gross amount of $1,508.33 [redacted]).

9) According to your application, you will file your 2017 tax return with a tax filing status of single, and you will claim no dependents on that tax return.

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

Applicable Law and Regulations

Enrollment in a Qualified Health Plan

The effective date of coverage by a QHP 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)). 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

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

level (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 $11,880.00 for a one-person household (81 Federal Register 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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 under review is whether NYSOH properly determined your enrollment in a QHP was effective no earlier than February 1, 2017.

According to your account, you submitted an updated application for financial assistance with health insurance on January 9, 2017, and you were determined eligible to receive $147.00 in monthly APTC. You testified, and your account confirms, you selected a QHP online the same day. According to your account, your coverage through this plan became effective February 1, 2017. You testified you have outstanding medical bills from December 2016 which total more than your QHP deductible, and you are seeking to have your coverage through your QHP backdated to December 1, 2016 to provide coverage for that month.

Pursuant to the above cited regulations, the effective date of coverage by a QHP is determined by the date on which an applicant selects a plan for enrollment. For selections received by NYSOH from the first to the fifteenth of any month NYSOH must generally ensure that coverage is effective the first day of the following month. 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.

The evidence establishes you selected your QHP on January 9, 2017. Because you selected the plan prior to the fifteenth day of the month, that plan properly became effective on the first day of the next following month; that is, February 1, 2017.

Therefore, the January 10, 2017 enrollment confirmation notice stating your coverage through your QHP became effective on February 1, 2017, is correct and must be AFFIRMED.

It is noted that although you submitted an application for financial assistance on December 30, 2016 and you were subsequently determined eligible to purchase a full cost QHP, had you selected a plan on the date, pursuant to the above regulations, the plan would still not have become effective until February 1, 2017.

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

According to your application, you expect to file your 2017 tax return as single and will claim no dependents; therefore, for the purposes of determining your Medicaid eligibility, you are in a one-person household.

According to your account, you submitted your application on January 9, 2017, and in that application, you requested help paying for medical bills in the month of December 2016. When an individual files an initial application for financial assistance, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether that application resulted in Medicaid eligibility going forward. Instead, an individual, who has filed an application for financial assistance through NYSOH, has the right to be evaluated for Medicaid for the three months prior to the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's 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 are appealing NYSOH's denial of your request for retroactive Medicaid coverage for the month of December 2016, as stated in the January 10, 2017 eligibility determination. 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 December 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL for a one-person household, which was $1,367.00 per month in 2016. There is

no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during December 2016.

Income documentation was uploaded to your NYSOH account, including two biweekly paystubs with check dates in December 2016 in gross amounts of $1,458.00 and $1,508.33. Accordingly, the evidence establishes you received $2,966.33 in gross income in the month of December 2016. As $2,966.33 is over the allowable income limit of $1,367.00 to qualify for Medicaid in the month of December 2016, you were not eligible for retroactive Medicaid coverage for that month.

Although the January 10, 2017 eligibility determination notice correctly stated you were not eligible for retroactive Medicaid coverage for the month of December 2016, the notice incorrectly stated the reason for the denial was because the "program you are eligible for cannot pay for any care you received in the past." This reasoning is inconsistent with the aforementioned regulations. Accordingly, the January 10, 2017 eligibility determination notice denying your request for retroactive Medicaid coverage for the month of December 2016 is MODIFIED to reflect you were not eligible for retroactive coverage in December 2016 because your household income of $2,966.33 in the month of December 2016 was over the allowable income limit of $1,367.00.

Decision

The January 10, 2017 enrollment confirmation notice is AFFIRMED.

The January 10, 2017 eligibility determination notice denying you retroactive Medicaid coverage for the month of December 2016 is MODIFIED to reflect you were not eligible for retroactive coverage in December 2016 because your household income of $2,966.33 in the month of December 2016 was over the allowable income limit of $1,367.00.

Your case is RETURNED to NYSOH to issue an updated eligibility determination notice in accordance with this decision.

Effective Date of this Decision: June 7, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

Your enrollment in your QHP properly became effective February 1, 2017.

You are not eligible for retroactive Medicaid coverage for the month of December 2016.

You will receive an updated eligibility determination notice from NYSOH correcting the reason for the denial of retroactive coverage for the month of December 2016 in accordance with this decision.

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 10, 2017 enrollment confirmation notice is AFFIRMED.

The January 10, 2017 eligibility determination notice denying you retroactive Medicaid coverage for the month of December 2016 is MODIFIED to reflect you were not eligible for retroactive coverage in December 2016 because your household income of $2,966.33 in the month of December 2016 was over the allowable income limit of $1,367.00.

Your case is RETURNED to NYSOH to issue an updated eligibility determination notice in accordance with this decision.

This decision does not change your eligibility.

Your enrollment in your QHP properly became effective February 1, 2017.

You are not eligible for retroactive Medicaid coverage for the month of December 2016.

You will receive an updated eligibility determination notice from NYSOH correcting the reason for the denial of retroactive coverage for the month of December 2016 in accordance with this decision.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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)

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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।

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.

(Urdu)اردو

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 פארשטייין, 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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