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

Notice of Decision

Decision Date: June 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016035

[redacted]

Dear [redacted],

On June 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 11, 2015 disenrollment notice and January 14, 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: June 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016035

[redacted]

Issues

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

> Did NY State of Health properly determine that you were eligible for Medicaid for October 1, 2015 through November 30, 2015, and not eligible for Medicaid for December 1, 2015 through December 31, 2015?
>
> Was your appeal of NY State of Health's December 11, 2015 disenrollment notice timely?
>
> Did NY State of Health properly determine that your enrollment in your qualified health plan ended effective December 31, 2015?

Procedural History

On November 14, 2015, you submitted an application for financial assistance with health insurance.

On November 15, 2015, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible to receive up to $33.00 per month in advance payments of the premium tax credit, effective December 1, 2015.

Also on November 15, 2015, NYSOH issued a notice of enrollment confirming your plan selection on November 14, 2015, stating that you were enrolled in your qualified health plan with a plan enrollment start date of December 1, 2015.

On December 9, 2015, you updated your application for financial assistance with health insurance.

On December 10, 2015, NYSOH issued a notice advising you that the income information you provided did not match what NYSOH had obtained from State and Federal data sources and that an eligibility determination could not be issued until income documentation was provided. This notice also directed you to submit documentation of your income by December 25, 2015.

On December 11, 2015, NYSOH issued a disenrollment notice stating that your enrollment in your qualified health plan would end on December 31, 2015.

On January 16, 2016, income documentation was uploaded to your NYSOH account.

On January 26, 2016, NYSOH verified the income documentation you submitted. That day, NYSOH submitted a new application on your behalf.

On January 27, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective January 1, 2016.

On February 2, 2016, a complaint ([redacted]) was created regarding the issue of your eligibility for Medicaid for December 2015 as well as your request to retroactively disenroll from your qualified health plan for the month of December 2015.

Also on February 2, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for October 2015, November 2015, and December 2015.

On January 14, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid for October 1, 2015 through November 30, 2015.

On February 21, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not granted retroactive Medicaid for the month of December 2015 as well as the date you were disenrolled from your qualified health plan, requesting the disenrollment be made effective December 1, 2015.

On June 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing closed at the end of the hearing.

Findings of Fact

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

1) You testified that you are seeking Medicaid from December 1, 2015 to December 31, 2015 and to be disenrolled from your qualified health plan as of December 1, 2015.

2) You testified that you filed your 2015 and 2016 federal tax returns as single, and claimed no dependents on those returns.

3) You submitted an application for financial assistance on December 9, 2015.

4) You uploaded an Official Record of Benefit Payment History from the Department of Labor. This shows that on December 2, 2015 you received $425.00 for the week ending November 15, 2015; also on December 2, 2015 you received $425.00 for the week ending November 22, 2015; on December 7, 2015 you received $425.00 for the week ending November 29, 2015; on December 14, 2015 you received $425.00 for the week ending December 6, 2015; on December 21, 2015 you received $425.00 for the week ending December 13, 2015; on December 28, 2015 you received $425.00 for the week ending December 27, 2015.

5) You testified that your only source of income in December 2015 was your Unemployment Insurance Benefits.

6) You testified that you selected your qualified health plan for enrollment yourself.

7) You explained that you were dissatisfied with being found eligible for a tax credit, and the qualified health plan that you enrolled in was the least expensive of the plan available to you.

8) On February 2, 2016, a complaint ([redacted]). The notes contained within that complaint show that at that time you requested to disenroll from your qualified health plan for December 2015. At the same time, you requested to be found eligible for Medicaid for the month of December 2015. The notes within that incident further indicate that the complaint was closed on February 4, 2016 as your application had been updated to request retroactive Medicaid for the months of October 2015, November 2015, and December 2015.

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

Applicable Law and Regulations

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 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 2015 FPL, which is $11,770.00 for a one-person household (80 Federal Register 3236, 3237).

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)).

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 the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (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 sixty (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)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

Termination of a Qualified Health Plan

NYSOH must permit an enrollee to terminate his or her coverage with a qualified health plan coverage, with appropriate notice to the NYSOH or qualified health plan (45 CFR § 155.430(b)(1)(i)).

For enrollee-initiated terminations, the last day of coverage is either:

1) The termination date specified by the enrollee, if the enrollee provides reasonable notice (at least 14 days before the requested termination date);

2) Fourteen days after the enrollee requests the termination, if they do not provide reasonable notice; or

3) On a date on or after the date the enrollee requests the termination, if the enrollee's qualified health plan issuer and the enrollee agree to such a date

(45 CFR § 155.430(d)(2)(i)-(iii)).

NYSOH must permit an enrollee to retroactively terminate or cancel their enrollment in a qualified health plan if:

1) The enrollee demonstrates that they attempted to terminate their coverage and experienced a technical error that did not allow the coverage to be terminated, and requests retroactive termination within 60 days after they discovered the technical error.

2) The enrollment in the qualified health plan was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of NYSOH or HHS, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment.

3) The enrollee was enrolled in a qualified health plan without their knowledge or consent by any third party, including third parties who have

no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

(45 CFR § 155.430(b)(2)(iv)(A-C)).

NYSOH permits a qualified health plan to terminate an individual's coverage if (1) the enrollee is no longer eligible for coverage or (2) non-payment of the premiums by the enrollee (45 CFR § 155.430(b)(2)(i)-(ii)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for Medicaid for October 1, 2015 through November 30, 2015, and not eligible for Medicaid for December 1, 2015 through December 30, 2015.

You are in a one-person household; you file your taxes with a tax filing status of single and claim no dependent on your tax return.

You submitted an application for financial assistance on February 2, 2016 and requested help in paying for medical bills for October 1, 2015 to December 31, 2015.

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 or not 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 that you are seeking Medicaid from December 1, 2015 to December 30, 2015.

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 2015, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,354.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during December 2015.

You uploaded an Official Record of Benefit Payment History from the Department of Labor. This shows that on December 2, 2015 you received $425.00 for the week ending November 15, 2015; also on December 2, 2015 you received $425.00 for the week ending November 22, 2015; on December 7, 2015 you received $425.00 for the week ending November 29, 2015; on December 14, 2015 you received $425.00 for the week ending December 6, 2015; on December 21, 2015 you received $425.00 for the week ending December 13, 2015; on December 28, 2015 you received $425.00 for the week ending December 27, 2015. The record indicates that in the month of December 2015, you received unemployment benefit payments of $2,550.00. Therefore, in December 2015 you had monthly household income of $2,550.00.

Since your income of $2,550.00 was more than the $1,354.00 monthly Medicaid limit for December 2015, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the January 14, 2017 eligibility determination stating that you were eligible for Medicaid for October 1, 2015 through November 30, 2015 and not December 1, 2015 through December 31, 2015, is correct and is AFFIRMED.

The second issue under review is whether your appeal of NYSOH's December 11, 2015 disenrollment notice was timely.

The record reflects that you first contacted NYSOH to file a formal appeal regarding your disenrollment date from your qualified health plan on February 21, 2017. You also appealed regarding your retroactive Medicaid eligibility for December 2015.

Individual applications and enrollees must request a hearing within sixty (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 disenrollment date from your qualified health plan, an appeal should have been filed by February 9, 2016. The record reflects that you filed your appeal on February 21, 2017, which is beyond the 60-day deadline.

Although the appeal was untimely on its face, the record reflects that you contacted NYSOH and filed a complaint on February 2, 2016, which was within the 60-day deadline. This complaint, which indicated that you were seeking to disenroll from your qualified health plan for the month of December 2015 and seeking Medicaid for the month of December 2015, was closed on February 4, 2016 with a note indicating that your application was being updated to request retroactive coverage for October 1, 2015 through December 31, 2015. No determination was issued with regard to your retroactive Medicaid eligibility until January 14, 2017.

As it appears from this complaint that the issue of your request to disenroll from your qualified health plan for the month of December 2015 was to be addressed in conjunction with your request for Medicaid for the month of December 2015, and NYSOH did not make a determination regarding your retroactive Medicaid eligibility until January 14, 2017, your failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal.

The third issue under review is whether NYSOH properly determined that your enrollment in your qualified health plan ended effective December 31, 2015.

On November 15, 2015, NYSOH issued an eligibility determination notice stating that you were eligible for up to $33.00 per month in advance payments of the premium tax credit, effective December 1, 2015. You subsequently enrolled into a qualified health plan.

On December 11, 2016, NYSOH issued a disenrollment notice indicating you would be disenrolled from your qualified health plan effective December 31, 2015.

You testified that you are seeking retroactive disenrollment from your qualified health plan effective December 1, 2015.

NYSOH must permit an enrollee to be retroactively disenroll from their qualified health plan if the enrollee demonstrates that there was a technical error that should have allowed them to terminate coverage earlier, or if their enrollment in the plan was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of NYSOH, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, or the enrollee was enrolled into a qualified health plan without their knowledge or consent by a third party.

There is no indication in the record that your enrollment in a qualified health plan as confirmed in the November 15, 2015 enrollment notice was unintentional, inadvertent, or erroneous, nor was your enrollment in a qualified health plan the result of the error or misconduct of an officer, employee, or agent of NYSOH, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities. Furthermore, there is no indication that your enrollment in a qualified health plan as confirmed in the November 15, 2015 enrollment notice was without your knowledge or consent.

Therefore, there is no basis to find that NYSOH must permit you to retroactively terminate or cancel your enrollment in a qualified health plan.

Your qualified health plan ended on December 31, 2015 as qualified health plans terminate at the end of each calendar year.

The record reflects that you first contacted NYSOH and requested that you be retroactively disenrolled from your qualified health plan on February 2, 2016.

Enrollees must be allowed to terminate their coverage with a qualified health plan at the date they specify if they provide reasonable notice to NYSOH or to their health plan. Reasonable notice is defined as at least 14 days prior to the requested termination date.

Since you do not qualify to be retroactively disenrolled from your coverage and you did not provide notice to NYSOH until your qualified health plan had already terminated, NYSOH properly determined that your disenrollment in your qualified health plan was effective December 31, 2015.

Therefore, the December 11, 2015 disenrollment notice is AFFIRMED.

Decision

The January 14, 2017 eligibility determination is AFFIRMED.

The December 11, 2015 disenrollment notice is AFFIRMED.

Effective Date of this Decision: June 16, 2017

How this Decision Affects Your Eligibility

You are not eligible for Medicaid in the month of December 1, 2015.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of December 31, 2015.

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 14, 2017 eligibility determination is AFFIRMED.

You are not eligible for Medicaid in the month of December 1, 2015.

The December 11, 2015 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of December 31, 2015.

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).