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

Notice of Decision

Decision Date: July 3, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000016066

Dear ,

On May 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 29, 2016, eligibility determination notice and the reimbursement of health insurance premiums.

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
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Decision

Decision Date: July 3, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000016066

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were not eligible for Medicaid as of November 29, 2016?
>
> Whether you are eligible to be reimbursed for the January and February 2017 premiums paid to your health plan?

Procedural History

On November 28, 2016, an application for financial assistance was submitted through NYSOH.

On November 29, 2016, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost, effective as of January 1, 2017.

Also on November 29, 2016, NYSOH issued an enrollment notice confirming that as of November 28, 2016, you were enrolled in a QHP with an enrollment start date of January 1, 2017.

On February 21, 2017, your NYSOH account was updated.

Also on February 21, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as the amount of financial assistance you were determined eligible to receive as of November 29, 2016, and the reimbursement of the health insurance premiums that you paid in January and February 2017.

On February 22, 2017, NYSOH issued three notices:

(1) An eligibility determination notice stating that you were eligible for Medicaid, effective as of February 1, 2017;

(2) An enrollment notice confirming that as of February 21, 2017, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of April 1, 2017.

(3) A disenrollment notice stating that your QHP coverage would end on February 28, 2017, because you were no longer eligible to enroll in that health plan.

On May 30, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until May 31, 2017, to allow you to submit additional income documentation.

On May 30, 2017, you faxed sixteen-pages of documents to NYSOH's Appeals Unit. That documentation has been incorporated into the record and will be referred to as "Appellant Exhibit [redacted] The record is complete and closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are seeking health insurance for yourself.

2) According to your November 28, 2016, you expected to file your federal income tax return, with the tax status of single, and did not expect to claim any dependents on that tax return.

3) According to your November 28, 2016 application, you attested:

    (a) You were employed at [redacted]. in 2016 from January 1, 2016 through October 1, 2016 and was issued $90,000.00 during that period;

    (b) You were currently receiving unemployment insurance benefits (UIB) at a weekly rate of $430.00.

4) Your separation with the [redacted] was effective September 29, 2016, and your final paycheck was mailed on October 14, 2016 (Appellant Exhibit [redacted]

5) According to the printout of your Official Record of Benefit Payment History from the New York State Department of Labor, you were eligible for a maximum benefit amount of $11,180.00 from October 17, 2016 through October 22, 2017 (Appellant Exhibit [redacted]

6) According to your NYSOH account, you enrolled in a bronze-level QHP on November 28, 2016, with an enrollment start date of January 1, 2017.

7) On December 9, 2016 and February 1, 2017, you paid your January and February 2017 monthly health insurance premiums in the amounts of $409.07 (Appellant Exhibit [redacted].

8) You testified that payment for the medical services that were received in January and February 2017 were denied by your QHP. You submitted invoices for the medical services that were denied payment (Appellant Exhibit [redacted]

9) You testified that you want to be determined eligible for Medicaid as of November 28, 2016, and to be reimbursed for the January and February 2017 premiums that were paid to the QHP.

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

Applicable Law and Regulations

Medicaid:

Medicaid can be provided through the Marketplace 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 that is at or below 138% of the federal poverty for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.603(d)(4)), N.Y. Soc. Serv. Law § 366(1)(b)).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

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 Fed. Reg. 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 by the US Department of Health and Human Services, March 19, 2014).

In determining current monthly or projected annual household income and family size, NYSOH may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income (42 CFR § 435.603(h)(3), State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Appealable Issues

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 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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were ineligible for Medicaid as of November 29, 2016.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size, which is $16,395.00 for a one-person household.

The record reflects that you expected to file your 2016 federal income tax return, with the tax status of single, and did not claim any dependents on that tax return. Therefore, you were in a one-person household.

According to your November 28, 2016 application, you were employed at [redacted] in 2016 from January 1, 2016 through October 1, 2016, and were currently receiving UIB at a weekly rate of $430.00.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. When determining household income and family size, NYSOH has adopted to provide a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income.

The record reflects that NYSOH was aware that you were unemployed, and your only income for the foreseeable future were your $430.00 payments in UIB. Your maximum amount payable in UIB was $11,180.00 from October 17, 2016 through October 22, 2017. The maximum amount of UIB issued was unable to exceed the Medicaid income threshold of $16,395.00. Therefore, NYSOH improperly determined you ineligible for Medicaid as of November 29, 2016.

The November 29, 2016 eligibility determination is MODIFIED to state that you were eligible for Medicaid.

Your case is RETURNED to NYSOH to enroll you in Medicaid coverage as of November 29, 2016.

The second issue under review is the reimbursement for the premiums paid to the QHP for the months of January and February 2017.

NYSOH Appeals Unit only has the authority to review issues related to the following: (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 to provide timely notice of an eligibility determination and (5) a denial of a special enrollment period.

The Appeals Unit is not given the authority to review the issue pertaining to the reimbursement of health insurance premiums. Therefore, we cannot reach the merits as to whether you are eligible to be reimbursed for the premiums paid to the QHP. The issue is DISMISSED as a non-appealable issue.

Since your issue concerns a health insurer and/or payment, reimbursement, coverage, benefits, rates and premiums, you can contact NY Department of Financial Services at their Consumer Hotline at (800) 342-3736 (Monday through Friday, 8:30 AM to 4:30 PM); or locally to (212) 480-6400; or you can file a complaint at http://www.dfs.ny.gov/consumer/fileacomplaint.htm.

Decision

The November 29, 2016 eligibility determination is MODIFIED to state that you were eligible for Medicaid.

Your case is RETURNED to NYSOH to enroll you in Medicaid coverage as of November 29, 2016.

Your appeal regarding the reimbursement of premiums is DISMISSED as a non-appealable issue.

Effective Date of this Decision: July 3, 2017

How this Decision Affects Your Eligibility

NYSOH failed to determine you eligible for Medicaid as of November 29, 2016.

Your case will be sent back to NYSOH to enroll you in Medicaid coverage as of November 29, 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 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 29, 2016 eligibility determination is MODIFIED to state that you were eligible for Medicaid.

Your case is RETURNED to NYSOH to enroll you in Medicaid coverage as of November 29, 2016.

Your appeal regarding the reimbursement of premiums is DISMISSED as a non-appealable issue.

NYSOH failed to determine you eligible for Medicaid as of November 29, 2016.

Your case will be sent back to NYSOH to enroll you in Medicaid coverage as of November 29, 2016.

Legal Authority

We are sending you this notice 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.

□□□□□ (Bengali)

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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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)

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).