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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017882

[redacted]

Dear [redacted],

On July 25, 2017, you both appeared by telephone at a hearing on your appeal of NY State of Health's April 4, 2017 notice stating that your family was not eligible for Medicaid Premium Assistance Payments.

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

Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017882

[redacted]

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 your family was ineligible for Medicaid Premium Assistance Payments?

Procedural History

On March 27, 2017, NYSOH received your initial application for health insurance for your family.

On March 28, 2017, NYSOH issued an eligibility determination notice based on the information contained in the March 27, 2017 application. The notice stated that you, your spouse and your child were eligible for Medicaid, effective March 1, 2017. The notice stated that the type of Medicaid coverage your family was eligible for does not require or allow you and your family to enroll in a health plan because you were all enrolled in other (full benefit) health insurance or Medicare.

According to your NYSOH account, on March 31, 2017, you uploaded documentation in support of your application for premium assistance payments with your family's COBRA coverage and copies of your family's COBRA coverage health insurance cards (*see* Documents [redacted] and [redacted]).

On April 4, 2017, NYSOH issued a notice stating that NYSOH had determined that you, your spouse and your child were not eligible for payment of health

insurance premiums by NYSOH. This was because it was not cost effective for NYSOH to pay your health insurance premiums.

On April 10, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the April 4, 2017 determination notice insofar as you, your spouse and your child were not eligible for the Medicaid Premium Assistance Program.

On July 25, 2017, you and your spouse had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open until April 8, 2017, as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: (1) documentary evidence reflecting proof of the monthly premium costs due for family COBRA coverage and the cost for employee only COBRA coverage; and, (2) up-to-date unemployment insurance benefit payment records.

On July 28, 2017, you uploaded proof of termination of COBRA coverage for you and your child effective July 1, 2017. On July 29, 2017, you uploaded to your account four documents including a cover letter, a COBRA enrollment form showing coverage costs, a COBRA election of benefits form, a form showing COBRA premium cost rate increase as of June 1, 2017, a check showing proof of payment for your spouse's COBRA premium payment for July 2017.

On August 2, 2017, you uploaded to your NYSOH account the official Record of Benefit Payment History for your unemployment benefits that shows your last payment for the week ending July 23, 2017 was released on July 25, 2017 (*see* Documents [redacted] .

Collectively, all of these uploaded documents have been made part of the record as Appellant's Exhibit # 1. The record was closed at that time.

Findings of Fact

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

1) According to your NYSOH account and your testimony, you, your spouse and your child were determined eligible for Medicaid effective March 1, 2017.

2) According to your NYSOH account and your testimony, your family began COBRA coverage as of January 1, 2017 because you lost employment at that time.

3) According to your NYSOH account and your testimony, the monthly premium for COBRA coverage for your family starting January 1, 2017 was $2,299.08.

4) According to your NYSOH account, the cost of employee only COBRA coverage was $756.84 thru June 1, 2017 and is now $852.72 for COBRA coverage for your spouse.

5) You testified that the COBRA cost for an individual person is the same as if is for employee only coverage.

6) According to your NYSOH account and your testimony, you dropped the COBRA coverage for yourself and your child and as of July 1, 2017, and only your spouse is on COBRA coverage with a monthly premium of $852.72.

7) Your spouse testified that she is concerned about her continuity of care due to the multiple doctors that are treating her for long standing illnesses. You both desire for her to be able to remain enrolled under her COBRA plan with the financial assistance of premium payments through Medicaid.

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

Applicable Law and Regulations

The state or local agency administering Medicaid programs must take all reasonable measures to ascertain the legal liability of third parties (Social Security Act § 1902(a)(25); 42 USC § 1396(a)). Third parties include health insurers, self-insured plans, group health plans, service benefit plans, managed care plans, etc., that are legally responsible for payment of a claim for a health care item or service (*id.*).

In New York, payment of the premiums for COBRA continuation coverage is made by the Medicaid program for services of health care providers (18 NYCRR § 360-7.5(h)(1)(i), (a)(2)). The Medicaid assistance program will pay premiums for COBRA continuation coverage if it is determined that the savings in Medicaid expenditures are likely to exceed the amount of premium payments for COBRA (18 NYCRR §360-7.5(h)(2)).

The cost-benefit analysis for COBRA premiums that is to be relied upon by NYSOH is performed by the Department of Health's Third Party Resource Unit (13 ADM 03 [Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010], Section III, Subsection I). The unit performs this analysis using a programmed calculator known as HIPP calculator (GIS 13 MA/012 (May 1, 2013)). The determinations of cost effectiveness are subject to appeal (13 ADM 03, Section III, Subsection J).

Legal Analysis

The issue under review is whether NYSOH properly determined that you, your spouse and your child were ineligible for Medicaid Premium Assistance Payments as of April 4, 2017.

According to your NYSOH account and your testimony, your family went on COBRA coverage effective January 1, 2017 because you lost employment at that time. You and your spouse testified that she needed to maintain continuity of health care providers through COBRA because she has been treating with multiple doctors for many years due to longstanding illnesses.

Your family was found Medicaid eligible by NYSOH effective March 1, 2017. As your family had COBRA coverage at that time, your family was not allowed to select a Medicaid Managed Care plan and coverage through Medicaid was secondary to your COBRA coverage.

On March 31, 2017, along with your initial application for financial assistance with NYSOH, you submitted documentation in support of your application for premium assistance payments for your family's COBRA coverage.

On April 4, 2017, NYSOH issued a notice stating that NYSOH had determined that you, your spouse and your child were not eligible for payment of health insurance premiums by NYSOH. This was because it was not cost effective for NYSOH to pay your health insurance premiums.

The record reflects that you and your child began receiving full Medicaid Fee-For-Service as of July 1, 2017, and are to be enrolled in a Medicaid managed Care plan as of September 1, 2017. Therefore, you are seeking Medicaid Premium Assistance Payments for your spouse's premiums with COBRA.

At the July 25, 2017 hearing, the Hearing Officer requested that you submit proof of monthly premium costs due for family COBRA coverage and the cost for employee only COBRA coverage and up-to-date unemployment insurance benefit payment records. On July 28, 2017, you uploaded proof of termination of COBRA coverage for you and your child, effective July 1, 2017. On July 29, 2017, you uploaded to your account four documents including a cover letter, a COBRA enrollment form showing coverage costs, a COBRA election of benefits form, a form showing COBRA premium cost rate increase as of June 1, 2017, and a check showing proof of payment for your spouse's COBRA premium payment for July 2017. On August 2, 2017 you uploaded to your NYSOH account the official Record of Benefit Payment History for your unemployment benefits that shows your last payment for the week ending July 23, 2017 was released on July 25, 2017.

Your case is RETURNED to NYSOH to redetermine your spouse's eligibility for Medicaid Premium Assistance Payments based on the updated documentation

showing COBRA premium costs for employee only (individual member) coverage, COBRA premium cost increase of monthly premium as of June 1, 2017 of $852.72, proof of payment for COBRA premium for your spouse only as of July 1, 2017, and the final listing of your unemployment insurance benefits as of July 25, 2017.

Decision

Your case is RETURNED to NYSOH to redetermine your spouse's eligibility for Medicaid Premium Assistance Payments based on the updated documentation showing COBRA premium costs for employee only (individual member) coverage, COBRA premium cost increase of monthly premium as of June 1, 2017 of $852.72, proof of payment for COBRA premium for your spouse only as of July 1, 2017, and the final listing of your unemployment insurance benefits as of July 25, 2017.

Effective Date of this Decision: August 24, 2017

How this Decision Affects Your Eligibility

You will receive a redetermination from NYSOH on your family and spouse's eligibility for Medicaid Premium Assistance Payments based on the updated information you provided after the hearing.

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

Your case is RETURNED to NYSOH to redetermine your spouse's eligibility for Medicaid Premium Assistance Payments based on the updated documentation showing COBRA premium costs for employee only (individual member) coverage, COBRA premium cost increase of monthly premium as of June 1, 2017 of $852.72, proof of payment for COBRA premium for your spouse only as of July 1, 2017, and the final listing of your unemployment insurance benefits as of July 25, 2017.

You will receive a redetermination from NYSOH on your family and spouse's eligibility for Medicaid Premium Assistance Payments based on the updated information you provided after the hearing.

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).

Legal Authority

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

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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)

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).

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 नि:शुल्क 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.

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