STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: October 31, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019100

[redacted]

Dear [redacted],

On August 29, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of your request 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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Decision

Decision Date: October 31, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019100

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) improperly fail to find your family eligible for Medicaid Premium Assistance Payments?

Procedural History

On March 8, 2017, NYSOH issued an eligibility determination stating that you and your family were eligible for Medicaid, effective April 1, 2017. That notice also noted that you and your family were enrolled in other, full-benefit health insurance, or were eligible to so enroll, so your family was not eligible to enroll in a Medicaid Managed Care plan. The notice also advised you that you could apply to have your premiums for that coverage reimbursed, and Medicaid might assist you.

On April 25, 2017, NYSOH issued a notice of eligibility determination, stating that you and your family were not eligible for Medicaid Premium Assistance Payments, because it would not be cost-effective.

On May 18, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of NYSOH's determination that you and your family were not eligible for the Medicaid Premium Assistance Program.

On August 29, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open, because the Hearing Officer directed you to provide

documentation regarding the cost of individual health insurance and the amount of the deductible for the plans offered through your employer.

On August 29, 2017, you provided to the Appeals Unit a letter from your employer indicating the cost to have this policy with single coverage was $51.86 per week. Also submitted was documentation of the plans available to you through your employer.

The record was then closed.

Findings of Fact

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

1) You and your family were found eligible for Medicaid coverage, effective April 1, 2017. Because you and your family had health insurance outside of NYSOH, you were not eligible to enroll in a Medicaid Managed Care plan through NYSOH. However, you were eligible to apply for assistance through the Medicaid Premium Assistance Program.

2) On April 25, 2017, NYSOH issued a notice of eligibility determination, stating that you and your family were not eligible for Medicaid Premium Assistance Program, because it would not be cost-effective

3) On August 23, 2017, NYSOH provided documentation in support of its determination that you and your family were not eligible for the Medicaid Premium Assistance Program. It clarified that the reason such reimbursement would not be cost-effective was because a high-deductible plan, with a 2017 deductible of $1,300.00 or more for an individual or $2,600.00 or more for a family, will not qualify for reimbursement. The documentation indicated that NYSOH had been advised that your policy had a $3,000.00 family deductible, and that it therefore was over the allowable limit and did not qualify for reimbursement.

4) In the documentation you provided to the Appeals Unit, dated August 29, 2017, your employer indicated that you and your family were enrolled in the [redacted] with Independent Health. According to the store catalogue, the deductible for in Network care for both an individual and “cumulative” is $0; for out of network care, $6,500.00 and $12,700.00, respectively.

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.*).

States must offer a premium assistance subsidy in certain circumstances; however, federal law specifically excludes coverage that has a high deductible (42 USC § 1396e-1(b)(2)(B); *see* NY Social Services Law § 367-a(a)(1)(c); 18 NYCRR § 360-7.5(g)).

For 2017, the term "high deductible health plan" means a health plan that has an annual deductible which is not less than $1,300.00 for self-only coverage, and $2,600.00 for family coverage, and for which the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed $6,550.00 for self-only coverage or $13,100.00 for family coverage (adjusted for cost-of-living) (26 USC § 223(c)(2) and (g); 26 USC § 1(f)(3); IRS Rev. Proc. 2016-28).

Legal Analysis

The issue under review is whether NYSOH properly found that you and your family did not qualify for the Medicaid Premium Assistance program.

You and your family was found eligible for Medicaid, but you continued your family's coverage offered through your employer. For you and your family to be eligible for the Medicaid Premium Assistance program, reimbursement for the expense of your coverage through your employer would have to be cost-effective.

By law, for you to receive such reimbursement, the plan through your employer would have to have an annual deductible which is no more than $2,600.00 for family coverage, and a maximum of $13,100.00 for the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums).

According to the document provided by your employer, the [redacted] Family coverage through Independent Health had a cumulative in network deductible of $0, and maximum cumulative out of pocket expenses of $12,700.00.

Therefore, it appears that the deductible and maximum out of pocket costs are not a valid basis to deny your request for Medicaid Premium Reimbursement.

However, the Appeals Unit cannot complete the analysis of your eligibility, because your employer did not provide the cost to you for your entire family; it only included what the expense would be for yourself alone.

Decision

The Appeals Unit finds that the basis provided by NYSOH for denying your request for Medicaid Premium Assistance was not valid. Your case is RETURNED to NYSOH to clarify the cost of your family coverage, and to redetermine your family's eligibility for the Medicaid Premium Assistance Program.

Effective Date of this Decision: October 31, 2017

How this Decision Affects Your Eligibility

You will receive a new determination shortly on your family's eligibility for Medicaid Premium Assistance when you supply information regarding the premiums for your family.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The Appeals Unit finds that the basis provided by NYSOH for denying your request for Medicaid Premium Assistance was not valid. Your case is RETURNED to NYSOH to clarify the cost of your family coverage, and to redetermine your family's eligibility for the Medicaid Premium Assistance Program.

You will receive a new determination shortly on your family's eligibility for Medicaid Premium Assistance when you supply information regarding the premiums for your family.

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।

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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 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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