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

Notice of Decision

Decision Date: October 06, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019809

[redacted]

Dear [redacted],

On September 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 19, 2017 eligibility determination and enrollment confirmation notices.

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
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Decision

Decision Date: October 06, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019809

[redacted]

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 eligible to enroll in the Essential Plan, effective April 1, 2017, and not eligible for Medicaid?
>
> Did NYSOH properly determine that you were not eligible for a backdate of your Essential Plan to March 1, 2017?
>
> Are you eligible for retroactive Medicaid coverage for the month of March 2017?

Procedural History

On April 18, 2017, NYSOH received your application for health insurance.

On April 19, 2017, NYSOH issued a notice of eligibility determination, stating that you are eligible to enroll in the Essential Plan, with no monthly premium, effective April 1, 2017. You qualified for the Essential Plan because your income was less than the allowable income limit and you were in the first five years of your qualified immigration status or you are living in the United Stated under the color of law.

Also on April 19, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in an Essential Plan, effective April 1, 2017.

On May 18, 2017, you updated your application for financial assistance and indicated that you were seeking help paying for medical bills for March 2017.

On June 16, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of your eligibility insofar as you were not eligible for a backdate of your Essential Plan to March 1, 2017.

On September 11, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You are seeking insurance for yourself.

2) You testified that you will not be filing a tax return for 2017.

3) You testified that you have a B-2 Visa which expires on November 1, 2018.

4) You testified that you arrived in the United States in January 2017.

5) The application that was submitted on April 18, 2017, which requested financial assistance, listed annual household income of $0.00.

6) On May 18, 2017, you updated your application for financial assistance and indicated that you were seeking help paying for medical bills for March 2017.

7) No eligibility determination has been issued to date regarding your request for retroactive Medicaid coverage for emergency medical care and services.

8) You testified that you had $0.00 income during the month of March 2017.

9) You testified that you will not be filing a tax return for 2017 because you have no income.

10) You testified that you are in the process of applying for an Employment Authorization Card.

11) You testified that you are seeking to have your Essential Plan backdated to March 1, 2017 or be determined eligible for Retroactive Medicaid for

emergency medical care and services because you incurred medical bills during March 2017.

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

Applicable Law and Regulations

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). 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).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

Medicaid

A person who meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard is eligible for Medicaid benefits (45 CFR § 155.305(c)). One of the non-financial criteria for Medicaid eligibility is the immigration status of the person applying for health

insurance. A person is eligible for Medicaid when his or her immigration status is satisfactory and he or she meets all other requirements for Medicaid (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 2017 FPL, which is $12,060.00 for a one-person household (82 Federal Register 8831).

Qualified Immigrants

In NY State, qualified immigrants who were formerly eligible for Medicaid through the state, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of January 1, 2016 (New York's Basic Health Plan Blueprint, p. 19, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html). This category of qualified immigrants includes individuals lawfully admitted for permanent residence in the United States who are still in their first five years of permanent residency. (18 NYCRR § 349.3, 8 USC § 1613).

Retroactive Medicaid

The Department of Health must make Medicaid coverage available 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 that you were eligible to enroll in the Essential Plan, effective April 1, 2017, and not eligible for Medicaid.

The application that was submitted on April 18, 2017 listed an annual household income of $0.00 and the eligibility determination relied upon that information.

According to your application, you are in a one-person household. You testified that you will not be filing a tax return for 2017.

The Essential Plan is provided through NYSOH to individuals who are lawfully present non-citizens who are ineligible for Medicaid or Child Health Plus as a result of their immigration status, and have a household income that is between 0% and 200% of the FPL. 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.

On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since an annual income of $0.00 is 0.00% of the 2016 FPL and 0.00% of the 2017 FPL, you meet the financial eligibility criteria for both the Essential Plan and Medicaid.

However, you testified that you are an immigrant non-citizen and have a B-2 Visa with an expiration date of November 1, 2018. You testified that you arrived in the United States in January 2017. As of January 1, 2016, legal permanent residents who were receiving Medicaid through NY State, but were not eligible for Medicaid under federal law due to being in the first five years of their permanent residency, must now receive coverage through the Essential Plan. Therefore, because you are in your first five years of permanent residency, NYSOH properly determined that you do not meet the non-financial requirements for Medicaid.

Since you meet the non-financial and financial requirements for the Essential Plan, NYSOH properly determined you to be eligible for Essential Plan coverage.

The second issue under review is whether NYSOH properly determined that you were not eligible for a backdate of your Essential Plan to March 1, 2017.

On April 18, 2017, NYSOH received your application for health insurance and on April 19, 2017, NYSOH issued a notice of eligibility determination, stating that you are eligible to enroll in the Essential Plan, effective April 1, 2017.

You testified that you are seeking to have your Essential Plan backdated to March 1, 2017 because you incurred medical bills during March 2017. The Essential Plan does not provide for retroactive insurance coverage to assist with medical bills. As such, NYSOH properly determined that your Essential Plan start date was April 1, 2017 and that you were not eligible for a backdate of your Essential Plan coverage to March 1, 2017.

Therefore, since the April 19, 2017 eligibility determination and enrollment confirmation notices properly stated that, based on the information you provided, you were eligible for the Essential Plan effective April 1, 2017, they were correct and are AFFIRMED.

The third issue is whether you are eligible for Retroactive Medicaid coverage for emergency medical care and services during the month of March 2017.

Your application dated May 18, 2017 states that you are seeking help paying for past medical bills. You testified that you are seeking retroactive Medicaid coverage for the month of March 2017. However, NYSOH did not issue a notice of eligibility determination or redetermination regarding your request for retroactive Medicaid for emergency medical care and services during the month of March 2017.

Here, the lack of a notice of eligibility determination on the issue of Retroactive Medicaid does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH's failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

When an individual file 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 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.

You testified that you are seeking retroactive Medicaid coverage for the month of March 2017.

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 March 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which was $1,387.00 per month in 2017. There is no indication in the record that you would have been ineligible for retroactive Medicaid for emergency medical care and services based on any non-financial criteria during March 2017.

You testified that you had $0.00 income during the month of March 2017. You also testified that you will not be filing a tax return for 2017 because you have no income. As such, the record reflects that your household's gross monthly income for March 2017 was $0.00.

Therefore, your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for March 2017, based on a household size of one person and household income of $0.00 for the month of March 2017.

Decision

The April 19, 2017 eligibility determination and enrollment confirmation notices are AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid for March 2017 based on a household size of one person and household income of $0.00 for the month of March 2017.

Effective Date of this Decision: October 06, 2017

How this Decision Affects Your Eligibility

You remain eligible for the Essential Plan.

Your Essential Plan is effective April 1, 2017.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid for March 2017 based on a household size of one person and household income of $0.00 for the month of March 2017.

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 April 19, 2017 eligibility determination and enrollment confirmation notices are AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid for March 2017 based on a household size of one person and household income of $0.00 for the month of March 2017.

You remain eligible for the Essential Plan.

Your Essential Plan is effective April 1, 2017.

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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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