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

Notice of Decision

Decision Date: December 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021139

Dear [redacted],

On October 18, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: December 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP00000021139

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 you were ineligible for Medicaid Premium Assistance Payments for the months of September, October, November, and December 2016?

Procedural History

On December 13, 2016, NYSOH received your application for health insurance.

On December 14, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective December 1, 2016.

Also on December 14, 2016, NYSOH issued a notice stating that your request for retroactive coverage for the three-month period prior to your application had been received. The notice directed you to submit documentation of your income for the months of September, October, and November 2016, by December 28, 2016, for your eligibility to be determined.

Additionally, on December 14, 2016, NYSOH issued a notice of enrollment, based on your December 13, 2016 plan selection, confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2017.

On March 28, 2017, NYSOH received your written request for Medicaid Premium Assistance Payments (PAP) for the months of September, October, November, and December 2016.

On April 7, 2017, NYSOH issued an eligibility determination notice stating you were eligible for retroactive Medicaid coverage for the months of September, October, and November 2016.

On August 3, 2017, NYSOH denied your request for PAP for the months of September 2016 through December 2016 and advised you of the determination by phone the same day.

Also on August 3, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal of NYSOH's denial of your request for PAP.

On October 6, 2017, a thirteen-page evidence packet from NYSOH's Third Party Liability Unit was uploaded to your NYSOH account. Page two of the packet indicated that your request for PAP was denied because it was not cost effective pursuant to Department regulations and administrative guidelines. Page three explained that "It is our Department's policy not to reimburse an individual for Third Party Health Insurance (TPHI) premiums paid during the three-month retroactive eligibility period, because such costs have already been avoided. Furthermore, eligibility for reimbursement of cost-effective TPHI is determined from the month of application for premium reimbursement through the end of the consumer's Medicaid eligibility."

On October 18, 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) NYSOH records confirm that account [redacted] was created on December 13, 2016 and an application for health insurance was submitted on your behalf under that account the same day.

2) That application requested retroactive health coverage for the months of September, October, and November 2016.

3) NYSOH determined you eligible for Medicaid, effective December 1, 2016.

4) You selected a Medicaid Managed Care plan on December 13, 2016. Coverage through that plan became effective on January 1, 2017.

5) You were directed to submit documentation of your income before a determination of your eligibility for retroactive coverage could be made.

6) On March 28, 2017, NYSOH received your written request for PAP for the months of September, October, November, and December 2016 indicating you made premium payments in each of those months in the amount of $618.61.

7) On April 7, 2017, NYSOH issued an eligibility determination notice stating you were eligible for retroactive Medicaid coverage for the months of September, October, and November 2016.

8) On July 28, 2017 [redacted] was created regarding your request for PAP. Notes from that incident indicate there was a previous issue of active third-party health insurance being detected on your account that prevented processing your PAP request until the issue was resolved. Notes from August 3, 2017 indicate your request for PAP was denied, because such payments were "not available during retro-active period."

9) According to your account, you were advised by telephone on August 3, 2017 of NYSOH's determination to deny your request for PAP for the months of September 2016 through December 2016.

10) You testified that your employer sponsored insurance coverage ended on March 31, 2016 and that you opted to continue that coverage through COBRA until December 31, 2016.

11) You testified that you initially attempted to apply for health insurance through NYSOH in July 2016, but you experienced technical issues with the application.

12) You testified that you needed health insurance, so you continued to pay the premiums for your COBRA coverage until the issues with your application were resolved.

13) There is no record of any activity on account [redacted] prior to December 13, 2016.

14) You testified that you are seeking reimbursement of your COBRA premiums for the retroactive period in which you were determined eligible for Medicaid, because the delay in getting Medicaid Managed Care coverage was NYSOH's fault and you needed health coverage during that period.

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

Applicable Law and Regulations

Medicaid Premium Reimbursement

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 (42 USC § 1396(a)).

The Medicaid assistance program will pay the health insurance premiums for personal health insurance covering care and other medical benefits which are authorized under the Medicaid program for cost-effective, employer-sponsored group health insurance benefits. Such premiums can also be paid for the benefit of the recipient's spouse and dependent children (18 NYCRR § 360-7.5(g)(1).

The cost-benefit analysis for premiums that is to be relied upon by NY State of Health 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).

Premium Reimbursement for Retroactive Medicaid Period

It is not cost effective for the Medicaid program to reimburse an individual for the cost of third party health insurance premiums paid during the three-month retroactive eligibility period. Costs covered by private insurance in the three-month retroactive eligibility period have already been avoided. Eligibility for reimbursement of cost-effective third-party health insurance is determined for the month of application and subsequent months (GIS 15 MA/04 (March 25, 2016)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were ineligible for Medicaid Premium Assistance Payments for the months of September, October, November, and December 2016.

You were determined eligible for Medicaid, effective December 1, 2016. You enrolled in a Medicaid Managed Care plan, effective January 1, 2017. On March 28, 2017, NYSOH received your written request for PAP for the months of September, October, November, and December 2016 indicating you made premium payments in each of those months in the amount of $618.61.

Subsequently NYSOH determined you eligible for retroactive Medicaid coverage for the months of September, October, and November 2016.

Your account confirms that NYSOH denied your request for PAP on August 3, 2017. You appealed that denial and testified that you are seeking reimbursement of COBRA premiums for the retroactive period in which you were determined eligible for Medicaid, because the delay in getting Medicaid Managed Care coverage was NYSOH's fault and you needed health coverage during that period. It is noted, however, that there is no record of any activity on account [redacted] prior to December 13, 2016, wherein your initial application for health insurance was submitted to NYSOH under that account.

Notwithstanding the date in which you initially applied for health insurance through NYSOH, pursuant to the regulations the Medicaid assistance program will only pay third party health insurance premiums for medical benefits which are authorized under the Medicaid program for cost-effective, employer-sponsored group health insurance benefits. Furthermore, according to Department policy, it is not cost effective for the Medicaid program to reimburse an individual for the cost of third party health insurance premiums paid during the three-month retroactive eligibility period, because those costs have already been avoided.

The record establishes that your written request for PAP was not received by NYSOH until March 28, 2017 and that you are requesting PAP for third party health insurance premium payments made during the retroactive Medicaid eligibility period. Since such premium payments are deemed to not be cost effective pursuant to Department policy, as outlined in General Information System message GIS MA/04 issued on March 25, 2015, NYSOH properly denied your request for PAP.

Therefore, NYSOH's verbal denial of your request for PAP for the months of September, October, and November 2016 was correct and is AFFIRMED.

Decision

NYSOH's verbal denial of your request for Medicaid Premium Assistance Payments is AFFIRMED.

Effective Date of this Decision: December 11, 2017

How this Decision Affects Your Eligibility

You are not eligible to have the cost of your COBRA premium payments reimbursed, because those premium payments are not cost-effective, pursuant to NY State law and policy.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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

NYSOH verbal denial of your request for Medicaid Premium Assistance Payments is AFFIRMED.

You are not eligible to have the cost of your COBRA premium payments reimbursed because those premium payments are not cost-effective, pursuant to NY State law and policy.

Legal Authority

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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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 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.

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