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

Notice of Decision

Decision Date: November 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021223

[redacted]

[redacted]

On October 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 3, 2017 eligibility determination notice, and August 9, 2017 enrollment notice.

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: November 30, 2017

NY State of Health Account ID: [redacted]
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[redacted]

Issues

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

> Did NY State of Health properly determine your enrollment in the Essential Plan was effective September 1, 2017?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid for the month of May 2017?

Procedural History

On March 8, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with your health insurance,

On March 9, 2017, NYSOH issued a notice stating the income information in your application does not match what NYSOH received from state and federal data sources. The notice requested more information by March 23, 2017.

On April 21, 2017, NYSOH issued a notice stating you were eligible to enroll in the Essential Plan with a $20.00 per month premium, June 1, 2017.

On May 28, 2017, you selected an Essential Plan for enrollment.

On June 2, 2017, NYSOH issued an enrollment notice confirming your enrollment on May 28, 2017 in an Essential Plan with a start date of July 1, 2017.

On July 6, 2017, NYSOH issued an eligibility determination notice stating you request for help with paying medical bills from April 1 to June 30, 2017 was denied because the program you were eligible for cannot pay for any care you received in the past.

On July 21, 2017, NYSOH issued a disenrollment notice stating your enrollment with the Essential Plan would end July 1, 2017. The notice stated this was because you did not pay your insurance bill by the payment deadline.

On July 29, 2017, NYSOH issued an eligibility determination notice stating you were eligible for the Essential Plan with a $20.00 per month premium, effective September 1, 2017.

On August 3, 2017, NYSOH issued an eligibility determination notice stating you were not eligible for Medicaid for May 1, 2017 through May 31, 2017. The notice stated you were not eligible for Medicaid because the monthly household income you provided of $2,447.82 was over the allowable income limit of $1,868.00.

On August 7, 2017, you contacted the NYSOH Account Review Unit and requested an appeal of the start date of your Essential Plan, requesting that it begin May 1, 2017.

On August 9, 2017, NYSOH issued an enrollment notice confirming your enrollment on August 8, 2017, in an Essential Plan, effective September 1, 2017.

On October 18, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you testified you are seeking to be found eligible for Medicaid for the month of May 2017. 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 submitted an application to NYSOH for financial assistance on March 8, 2017.

2) You were determined eligible for the Essential Plan effective June 1, 2017.

3) You first enrolled in an Essential Plan on May 28, 2017.

4) You were disenrolled from your Essential Plan for non-payment of premium effective July 1, 2017.

5) You reenrolled in an Essential Plan on August 8, 2017.

6) You testified that you wanted your enrollment in an Essential Plan to begin on May 1, 2017 because you have outstanding medical bills which were not covered during that month and you were not determined eligible for Medicaid for that month.

7) You testified that you expect to file your 2017 federal income tax return as head of household, and claim your one child as a dependent.

8) You testified that you are seeking retroactive Medicaid coverage for the month of May 2017.

9) You testified that you are paid bi-weekly. You uploaded a paystub dated May 5, 2017 for a gross pay amount of $1,203.53 and a paystub dated May 19, 2017 for a gross pay amount of $1,085.04 in Documents [redacted].

10) You reside in [redacted]

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

Applicable Law and Regulations

Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Medicaid for Adults between the Ages of 19 and 65

Medicaid through NYSOH can be provided 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 (MAGI) that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); N.Y. Soc. Serv. 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 $16,240.00 for a two-person household (82 Fed. Reg. 8831).

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 March 19, 2014).

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of 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 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 issue is whether NYSOH properly determined that your enrollment in the Essential Plan was effective September 1, 2017.

You were found eligible for the Essential Plan as of June 1, 2017 but you did not enroll into a plan until May 28, 2017, which resulted in an effective date of July 1, 2017. You were subsequently disenrolled from your Essential Plan for non-payment of premium.

You submitted another application for financial assistance on July 28, 2017 and were determined eligible for the Essential Plan as of September 1, 2017. You then enrolled in a plan on August 8, 2017.

The date on which enrollment in an Essential Plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

On August 8, 2017, you selected an Essential Plan, so your enrollment properly took effect on the first day of the first month following month after August; that is, on September 1, 2017.

Therefore, the August 9, 2017 enrollment confirmation notice stating that your enrollment in the Essential Plan was effective September 1, 2017, is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for May 1, 2017 through May 30, 2017.

You are in a two- person household; you file your taxes with a tax filing status of head of household and claim one dependent on your 2017 tax return.

You testified that you are seeking to have Medicaid coverage retroactively applied for the month of May 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

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 May, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,868.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during May 2017.

You testified that you are paid bi-weekly. You uploaded a paystub May 5, 2017 for a gross pay amount of $1,203.53 and a paystub dated May 19, 2017 for a gross pay amount of $1,085.04. Therefore, the record indicates that in the month of May 2017, you had a monthly household income of $2,288.57.

Since your income of $2,288.57 was more than the $1,868.00 monthly Medicaid limit for May 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the August 3, 2017 eligibility determination stating that you were not eligible for Medicaid in the month of May 2017, is correct and is AFFIRMED.

Decision

The August 9, 2017 enrollment confirmation notice is AFFIRMED.

The August 3, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 30, 2017

How this Decision Affects Your Eligibility

Your enrollment in your Essential Plan is effective as of September 1, 2017.

You were not eligible for Medicaid for the month of May 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 August 9, 2017 enrollment confirmation notice is AFFIRMED.

The August 3, 2017 eligibility determination notice is AFFIRMED.

Your enrollment in your Essential plan was effective as of September 1, 2017.

You were not eligible for Medicaid for the month of May 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.

□□□□□ (Bengali)

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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.

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)

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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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