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

Notice of Decision

Decision Date: March 6, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000023951

Dear

On February 1, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 28, 2017, eligibility determination notice, and your and your spouse's eligibility for the Medicaid Health Insurance Premium Payment program during the month of January 2017.

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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: March 6, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023951

[redacted]

Issues

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

> Was your appeal of the NY State of Health's (NYSOH) February 28, 2017 eligibility determination notice timely?
>
> Did NYSOH properly determine you and your spouse ineligible for the Medicaid Health Insurance Premium Payment (HIPP) program for the month of January 2017?

Procedural History

On October 6, 2016, NYSOH issued you a renewal notice stating, in relevant parts, that you, your spouse, and eldest child had Medicaid coverage through Monroe County Department of Social Service (DSS) and your coverage would end on December 31, 2016. The notice also stated that records showed that you had a NYSOH account ([redacted]), and you should log into your account between November 16, 2016 and December 15, 2016, to make sure that the information is up-to-date.

On December 17, 2016, NYSOH issued an eligibility determination notice stating that you, your spouse, and children were eligible to purchase a qualified health plan at full cost, effective January 1, 2017.

On January 10, 2017, you submitted a financial assistance application through NYSOH.

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On January 11, 2017, NYSOH issued a notice stating, in relevant part, that the income information in your application did not match what NYSOH received from state and federal data sources. The notice instructed you to provide proof of income and benefit information for third party health insurance by January 25, 2017, to confirm your and your spouse's eligibility.

On January 26, 2017, your NYSOH account was updated.

On January 27, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that your eldest child was conditionally eligible for Medicaid, effective as of January 1, 2017.

Also on January 27, 2017, NYSOH issued a notice stating, in relevant part, that the income information in your application did not match what NYSOH received from state and federal data sources. The notice instructed you to provide proof of income and benefit information for third party health insurance by February 10, 2017, to confirm your and your spouse's eligibility.

On February 21, 2017, NYSOH issued a notice stating that Medicaid would not reimburse your child for their monthly health insurance premiums because it was not cost effective (*see* Document [redacted]; uploaded 4/28/2017).

On February 27, 2017, your NYSOH account was updated.

On February 28, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for Medicaid, effective February 1, 2017.

On March 27, 2017, NYSOH issued a notice stating that Medicaid would reimburse you, your spouse, and eldest child for your monthly health insurance premiums, effective February 1, 2018 (*see* Document [redacted]; uploaded 5/11/2017).

On November 27, 2017, your NYSOH account was updated.

On November 28, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse remained eligible for Medicaid, effective November 1, 2017.

Also on November 28, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for Medicaid from January 1, 2017, through January 31, 2017.

On January 17, 2018, an evidence packet from NYSDOH'S Third Party Liability Unit was uploaded to your NYSOH account (*see* Document [redacted]). This packet has been made part of the record as "NYSDOH Exhibit 1."

On February 1, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing and the record was fully developed. The record was closed at the end of the hearing.

Findings of Fact

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

1) You testified that you and your spouse are enrolled in employer-sponsored health insurance coverage through your spouse's employer, [redacted].

2) You testified that you want to be reimbursed for the employer-sponsored health insurance premium that you paid out-of-pocket for the month of January 2017.

3) You testified that you and your spouse were enrolled in Medicaid and the Medicaid HIPP program through Monroe County Department of Social Services (DSS) in 2016.

4) You testified that, in October 2016, you were informed by a representative from Monroe County DSS that your family's health insurance coverage would transition to NYSOH. You were told that you would receive a letter regarding the transition from NYSOH, but you never did.

5) According to your NYSOH account, on January 10, 2017, you initially completed an application for financial assistance through NYSOH.

6) According to your NYSOH account, you and your spouse were determined eligible for Medicaid, effective as of February 1, 2017.

7) On March 27, 2017, NYSOH issued a notice stating that Medicaid would reimburse you, your spouse, and eldest child for your monthly health insurance premiums, effective February 1, 2018 (*see* Document [redacted]).

8) According to your NYSOH account, on November 2, 2017, you requested an appeal insofar as your and your spouse's eligibility for Medicaid coverage and the Medicaid HIPP program for the month of January 2017.

9) According to your NYSOH account, on November 27, 2017, your account was updated to reflect that you and your spouse wanted help paying for medical bills for the month of January 2017.

10) According to NYSDOH'S Third Party Liability Unit evidence packet:

> It is our department's policy not to reimburse an individual for Third Party Health Insurance (TPHI) premium paid during the three-month retroactive eligibility period. Eligibility for reimbursement of cost-effective TPHI is determined for the month of application through the consumer's Medicaid eligibility
>
> (*see* NYSDOH Exhibit 1, p. 2).

11) You testified that you want to be reimbursed for the January 2017 health insurance premium that you paid to your spouse's employer-sponsored health insurance.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively 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)).

Medicaid Premium Reimbursement

When a Medicaid eligible individual has third party health insurance in force, the Medicaid program may determine to pay part all cost of the premiums when payment of the premium is determined to be cost-effective. By paying the premium, the Medicaid program may cost avoid claims that would otherwise be covered by Medicaid (*see* NYS Social Services Law § 367-a(1)(b), 18 NYCRR § 360-7.5(g)).

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 NYSOH is performed by the Department of Health's Third-Party Resource Unit (13 OHIP/ADM-03 [Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010], Section III, Subsection I).

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 (General Information System (GIS) 15 MA/04 (March 25, 2015)).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's February 27, 2017 eligibility determination notice was timely.

Applicants and enrollees must request a hearing within sixty days of the date stated on the notice of eligibility determination.

The NYSOH Appeals Unit only has the authority to review issues related to the following: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (3) an eligibility determination for an exemption, (4) a failure by NYSOH to provide timely notice

of an eligibility determination and (5) a denial of a request to vacate dismissal made by the NYSOH Appeals Unit.

For an appeal to have been valid on the issue of your and your spouse's eligibility for health insurance, as addressed in the February 28, 2017 notice, an appeal request should have been filed by April 29, 2017. According to the credible evidence in the record, a formal appeal was not filed until November 2, 2017. This date exceeds the 60-day limit from the February 28, 2017 eligibility determination notice and, therefore, is not timely.

Since your request to appeal the February 28, 2017 eligibility determination notice was not timely, the appeal is DISMISSED.

The second issue under review is whether NYSOH properly determined you and your spouse ineligible for the Medicaid HIPP program for the month of January 2017.

The record reflects that you and your spouse were initially determined eligible for Medicaid, effective February 1, 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application, if they would have been found eligible for Medicaid in any of the three months had an application been submitted.

On November 27, 2017, your NYSOH account was updated to reflect that you and your spouse requested help paying for medical bills for the month of January 2017. On the following day, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for Medicaid from January 1, 2017, through January 31, 2017.

The record reflects that you and your spouse were enrolled in employer-sponsored health insurance during the month January 2017, and want to be reimbursed for the premium that was paid for that month.

When an individual is eligible for Medicaid and has third-party health insurance, Medicaid may pay for some or the entire premium when payment of the premium is determined to be cost-effective. It is not cost-effective for Medicaid to reimburse an individual for the cost of third-party health insurance premiums during the three-month retroactive eligibility period because the costs have already been avoided.

Since your and your spouse's Medicaid eligibility for the month of January 2017 was based on retroactive Medicaid, you and your spouse were properly determined ineligible for reimbursement of the third-party health insurance premium for that month. Therefore, NYSOH properly determined that you and

your spouse were ineligible for the Medicaid HIPP program for the month of January 2017.

Decision

Your appeal of the February 28, 2017 eligibility determination notice was untimely, and is DISMISSED.

NYSOH properly determined that you and your spouse were ineligible for the Medicaid HIPP program for the month of January 2017.

Effective Date of this Decision: March 6, 2018

How this Decision Affects Your Eligibility

You and your spouse were properly determined to be ineligible to be reimbursed for your third-party health insurance premium for the month of January 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

Your appeal of the February 28, 2017 eligibility determination notice was untimely, and is DISMISSED.

NYSOH properly determined that you and your spouse were ineligible for the Medicaid HIPP program for the month of January 2017.

You and your spouse were properly determined to be ineligible to be reimbursed for your third-party health insurance premium for the month of January 2017.

Legal Authority

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

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)

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 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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