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

Notice of Decision

Decision Date: February 09, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024310

[redacted]

[redacted]

On January 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's verbal denial of a special enrollment period and November 14, 2017 eligibility determination 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: February 09, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024310

[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 did not qualify to enroll in a qualified health plan outside of the open enrollment period?
>
> Did NYSOH properly determine that you were not eligible for Medicaid from September 1, 2017 through October 31, 2017?

Procedural History

On September 7, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective September 1, 2016. You enrolled in a Medicaid Managed Care plan (MMC) with an effective start date of October 1, 2016.

On July 2, 2017, NYSOH issued a renewal notice stating it was time to renew your coverage for the upcoming coverage year. The notice informed you to select a health plan between July 16, 2017 and August 15, 2017. The notice also contained an eligibility redetermination stating that, effective September 1, 2017, you were eligible for advance payments of the premium tax credit (APTC) up to $106.17 per month, effective September 1, 2017, because federal and state data sources showed your income was between $16,395.00 and $47,520.00.

On July 17, 2017, NYSOH issued a disenrollment notice terminating your enrollment in your MMC plan, effective August 31, 2017.

On November 13, 2017, NYSOH received your updated application for financial assistance, at which time you also updated your address. That day, a preliminary eligibility determination was prepared finding you eligible to receive up to $95.00 in APTC, effective December 1, 2017 through December 31, 2017.

In that application, you requested help paying medical bills for the last three months.

Also on November 13, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as you were not able to enroll in a health plan outside of the open enrollment period for 2017.

On November 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive an APTC of up to $95.00 per month, effective December 1, 2017. It further stated that you must confirm your health plan selection by January 12, 2018.

Also on November 14, 2017, NYSOH issued a notice stating your request for help paying medical bills from September 1, 2017 through October 31, 2017, was denied because the program you were eligible for cannot pay for any care you received in the past.

On January 4, 2018, 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 testified that you are appealing the denial of a special enrollment period to be able to enroll into a qualified health plan through NYSOH effective September 1, 2017.

2) On November 13, 2017, you submitted an application for health insurance.

3) According to your NYSOH account, you lost your prior health insurance through your MMC plan as of September 1, 2017.

4) On November 13, 2017, you attempted to enroll in a qualified health plan, and requested a start date of September 1, 2017. You testified your request was denied verbally by a NYSOH representative that day.

5) An incident filed on November 13, 2017, shows a NYSOH representative indicated that, even though you were eligible to enroll in a qualified health plan effective December 1, 2017, you could not enroll until January 1, 2018, and were disputing not having a special enrollment period for 2017 coverage ([redacted]

6) Your application on November 13, 2017, states that you were seeking a special enrollment period based on becoming eligible for a qualified health plan with APTC.

7) You requested help paying medical bills for the last three months in your November 13, 2017 application. You testified you have medical bills for [redacted] in September 2017.

8) You testified your annual household income for 2017 was $44,800.00, and was correctly listed in your November 13, 2017 application.

9) You will be filing your 2017 tax return as single with no dependents.

10) You testified your last day of employment was November 30, 2017, and were in the process of applying for unemployment benefits during the time of your hearing.

11) According to your NYSOH account, after the hearing was conducted and the record closed, you were determined Medicaid eligible, effective January 1, 2018, and were granted Medicaid coverage retroactively to December 1, 2017.

12) According to your NYSOH account, you reside in Kings County, NY.

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

Applicable Law and Regulations

<u>De Novo Review</u>

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).

Enrollment in a Qualified Health Plan

NYSOH must provide annual open enrollment periods during which time qualified individuals may enroll in a qualified health plan and enrollees may change qualified health plans (45 CFR § 155.410(a)(1)).

For the benefit year beginning on January 1, 2017, the annual open enrollment period began on November 1, 2016, and extended through January 31, 2017 (45 CFR § 155.410(e)(2)).

The effective date of coverage by a qualified health 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)). 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)).

Special Enrollment Periods

After each open enrollment period ends, NYSOH provides special enrollment periods to qualified individuals. During a special enrollment period, a qualified individual may enroll in a qualified health plan, and an enrollee may change their enrollment to another plan. This is generally permitted when one or more number of explicit triggering events occurs (45 CFR § 155.420(d)).

Generally, if a triggering life event occurs, the qualified individual or enrollee has 60 days from the date of a triggering event to select a qualified health plan (45 CFR § 155.420(c)(1)).

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH 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 FPL for the applicable family size (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 Fed. Reg. 8831).

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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you did not qualify to enroll in a qualified health plan outside of the open enrollment period.

You testified that you are appealing the verbal denial of a special enrollment period to enroll into a health plan through NYSOH. The record does not contain a notice of eligibility determination or redetermination on the issue of special enrollment period. There is an eligibility determination notice, dated November 14, 2017, in which NYSOH stated you were eligible for APTC, effective December 1, 2017, and could select a health plan by January 12, 2018.

Here, the lack of a notice of eligibility determination on the issue of special enrollment periods 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 failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. Your credible testimony along with the Incident filed with NYSOH on November 13, 2017, (*see* [redacted]), stating that the reason for your appeal was "denial of SEP," permits an inference that NYSOH did deny your special enrollment request for coverage to be effective at an earlier date.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been given to the eligibility determination notice had it been issued.

Your initial appeal as identified by NYSOH representatives was to request a special enrollment period be granted to enroll into a qualified health plan. During your hearing you testified this was correct.

After your telephone hearing took place on January 4, 2018, however, you were determined Medicaid eligible, effective January 1, 2018, and were granted Medicaid coverage retroactively to December 1, 2017.

Should your appeal of the denial of a special enrollment period be successful, the earliest effective date of your enrollment would be December 1, 2017. This is because regular effective dates for enrollment in qualified health plans would have applied. 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. Because your application was received on November 13, 2017, the earliest your eligibility for and enrollment in a qualified health plan would be effective would have been December 1, 2017.

Therefore, since the issue of your inability to enroll in coverage is no longer in contention according to NYSOH and your account, it is not necessary to address the factual merits of your appeal request on this issue. You are now eligible for and enrolled in minimum essential coverage through Medicaid as of December 1, 2017.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for the months of September 2017 and October 2017.

You are in a one-person household for purposes of this analysis. This is because you file your taxes with a tax filing status of single and claim no dependents on your tax return.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial 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.

You submitted an application for financial assistance on November 13, 2017, and requested help in paying for medical bills for the prior three months, which would be August 2017, September 2017, and October 2017. You testified that you are looking for Medicaid coverage for September 2017, because of medical treatment you received that month. However, and to be thorough, since you were receiving Medicaid in August 2017, this Decision will address your eligibility for retroactive Medicaid for the months of September 2017 and October 2017.

When an individual files 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 or not 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.

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

You testified that your annual household income for 2017 was $44,800.00, as attested to in your November 13, 2017 application. Your last day of employment was November 30, 2017. NYSOH calculated your average monthly gross income to be $3,733.00, including in the months of September 2017 and October 2017. Therefore, your average income for each month would be over the allowable income limit of $1,387.00 for purposes of receiving Medicaid.

The notice issued on November 14, 2017, indicated you were denied retroactive Medicaid because the program you were eligible for could not pay for any care you received in the past. This statement is incorrect. As previously indicated, it does not matter if your initial application resulted in Medicaid going forward. You have the right to have your eligibility determined for the prior three months from your November 13, 2017 application regardless of your eligibility being determined for a qualified health plan.

Therefore, the November 14, 2017 eligibility determination notice stating your request for help paying medical bills for September 2017 and October 2017 was denied because the program you were eligible for cannot pay for any care you received in the past is MODIFIED to state you were ineligible for help paying medical bills because your monthly income of $3,733.00 was over the allowable income limit of $1,387.00 for Medicaid.

Decision

The issue of your denial of a special enrollment period to enroll in a qualified health plan is rendered MOOT by a subsequent eligibility determination giving you retroactive Medicaid as of December 1, 2017.

The November 14, 2017 eligibility determination notice stating your request for help paying medical bills for September 2017 and October 2017 was denied because the program you were eligible for cannot pay for any care you received in the past is MODIFIED to state you were ineligible for help paying medical bills

because your monthly income of $3,733.00 was over the allowable income limit of $1,387.00 to be eligible for Medicaid for September 2017 and October 2017.

Effective Date of this Decision: February 09, 2018

How this Decision Affects Your Eligibility

This decision has no effect on any determinations made after November 14, 2017.

You were ineligible for Medicaid retroactively for the months of September 2017 and October 2017 because your monthly income each month was over the allowable income limit for Medicaid.

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 case 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

The issue of your denial of a special enrollment period to enroll in a qualified health plan is rendered MOOT by a subsequent eligibility determination giving you retroactive Medicaid as of December 1, 2017.

The November 14, 2017 eligibility determination notice stating your request for help paying medical bills for September 2017 and October 2017 was denied because the program you were eligible for cannot pay for any care you received in the past is MODIFIED to state you were ineligible for help paying medical bills because your monthly income of $3,733.00 was over the allowable income limit of $1,387.00 to be eligible for Medicaid for September 2017 and October 2017.

This decision has no effect on any determinations made after November 14, 2017.

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).

You were ineligible for Medicaid retroactively for the months of September 2017 and October 2017 because your monthly income each month was over the allowable income limit for Medicaid.

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 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.

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).