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

Notice of Decision

Decision Date: February 20, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000025358

On February 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 10, 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 NY State of Health 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: February 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025358

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State Department of Health properly determine that your household was eligible for Medicaid Premium Assistance Program payments effective October 1, 2017?

Procedural History

Initially and out of chronological order, it is noted that, on January 29, 2018, in lieu of appearing at your telephone hearing, NYSDOH's Third Party Liability Unit submitted a copy of an evidence packet and documentation relied on in making the October 10, 2017 determination. This submission has been made part of the record collectively as NYSDOH Exhibit 1.

In chronological order, the following procedural history is noted:

On December 1, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating your spouse was eligible for Medicaid, effective November 1, 2016.

On December 7, 2016, NYS Department of Health (NYSDOH) issued a Request for Additional Information notice stating you needed to provide a copy of the front and back of your health insurance card and a copy of current paystubs showing the insurance premium deduction or a form DOH-5106 filled out by our employer ([redacted]).

On July 12, 2017, NYSOH received your household's application for financial assistance with health insurance.

On July 12, 2017, NYSOH received a copy of the front and back of your health insurance card ([redacted]).

On July 13, 2017, NYSOH issued an eligibility determination notice stating you and your nine children were conditionally eligible for Medicaid, effective July 1, 2017. Your spouse was determined to remain eligible for Medicaid, effective July 1, 2017. The notice requested you provide proof of your Third Party Health Insurance by July 27, 2017.

On July 21, 2017, NYSDOH sent you a second Request for Additional Information stating you needed to provide a copy of the front and back of your health insurance card and a copy of current paystubs showing the insurance premium deduction or a form DOH-5106 filled out by our employer ([redacted]).

On September 19, 2017, NYSDOH issued a notice stating it was unable to determine if your household qualified for Medicaid payment of third party health insurance premiums because a copy of a current paystub showing the insurance premium deduction or Form DOH-5106 filled out by your employer was not provided ([redacted]).

On October 2, 2017, you uploaded a copy of Form DOH-5106 ([redacted]).

On October 10, 2017, NYSOH issued a notice stating it was determined it would be cost effective for NYSOH to pay for health insurance premiums for your entire household. Premiums would be reimbursed as of October 1, 2017 ([redacted]).

On December 5, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the October 10, 2017 notice insofar as your household was provided premium reimbursement payments effective October 1, 2017, and not September 1, 2017.

On January 29, 2018, NYSDOH's Third Party Liability Unit submitted a copy of an evidence packet and documentation relied on in making the October 10, 2017 determination ([redacted]).

On January 30, 2018, a copy of NYSOH's evidence packet and NYSDOH's Third Party Liability Unit's evidence packets were available in your account.

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).

On February 8, 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 are seeking financial assistance with the cost of premiums associated with your spouse's employer sponsored health insurance for yourself and your children. You are requesting full premium payments be made as of September 1, 2017.

2) You testified during your hearing that partial payments of your spouse's premium responsibility were paid for May 2017, June 2017, July 2017, and August 2017 up to $2,047.00 outside of NYSOH, but no premiums were paid for September 2017. Your employer is now requesting the difference for the prior months and you would like NYSOH to assist in this payment.

3) You testified your household's monthly premium is $2,231.32.

4) You were determined eligible for premium assistance payments by NYSDOH's Third Party Liability Unit as of October 1, 2017.

5) NYSDOH's Third Party Liability Unit maintains all documentation was not received until October 2, 2017, and therefore a determination could not be made until "receipt of all necessary documentation to complete a HIPP Calculation" was received ( ).

6) The record supports NYSOH received Form DOH-5106 on October 2, 2017, when it was uploaded to your account (*s*).

7) You testified your Navigator provided this documentation to NYSOH after you went to them in late September 2017 or October 2017, but you were not sure exactly.

8) You testified you signed up to receive notices from NYSOH via regular U.S. Mail.

9) You confirmed your household's mailing address was correct and you have not moved or changed your address in 2017.

10) Your NYSOH account shows there have been no notices returned as undelivered from your address.

11) According to your NYSOH account, you will be filing your 2017 taxes as married filing jointly with nine dependent children. You testified this was correct.

12) Your application states that your family lives in [redacted], NY.

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)).

Medicaid Premium Reimbursement and Effective Date

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 U.S.C. § 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 Liability (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 a HIPP calculator (GIS 13 MA/012 (May 1, 2013)).

It has been determined to not be 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, 2015)).

Notice of Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

NYSOH must send a timely and adequate written notice of any determination affecting an individual's eligibility including approval, denial, termination or suspension of eligibility or a denial or change in benefits and services (42 CFR § 435.917(a)).

Legal Analysis

Initially, it is noted that through NYSOH, you and your children were determined eligible for Medicaid, effective July 1, 2017. The record indicates that your spouse had insurance coverage through his employer-sponsored insurance plan for a monthly cost of $2,231.32. You testified partial premium assistance was provided for the months of May 2017, June 2017, July 2017, and August 2017, up to $2,047.00 per month from a source outside of NYSOH. You further explained no premium was reimbursed by NYSOH for the month of September 2017. Your household became eligible for full premium assistance payments through NYSOH as of October 1, 2017. You are seeking full premium assistance through NYSOH for the months of May 2017, June 2017, July 2017, August 2017, and September 2017.

Therefore, your appeal is twofold: (1) You are seeking full premium assistance through NYSOH for the months of May 2017, June 2017, July 2017, August 2017, in which your household had partial premium assistance; and (2) You are seeking full premium assistance through NYSOH for the month of September 2017, in which your household had no premium assistance.

As to the first part, it is noted that the premium assistance your household received in May 2017, June 2017, July 2017, August 2017, was not through NYSOH.

NYSOH's 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 the Exchange to provide timely notice of an eligibility determination and (5) a denial of a request to vacate dismissal made by the New York State of Health Appeals Unit.

Since the Appeals Unit is not given the authority to review premium assistance provided outside of NYSOH, we cannot reach the merits as to whether your household should have received or been deemed eligible to receive full premium assistance in the months of May 2017, June 2017, July 2017, and August 2017. Therefore, your request that full premium assistance for those months through NYSOH be granted is DISMISSED as a non-appealable issue.

The issue under review is refined to whether NYSOH properly determined that your household was eligible for the Medicaid Premium Assistance Program payments effective October 1, 2017, and not as of September 1, 2017.

The Medicaid Premium 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.

For an employer-sponsored health insurance plan to be determined cost-effective for the purposes of the Medicaid Premium Assistance Program, NYSDOH's Third Party Liability Unit is required to perform an analysis of cost effectiveness. This analysis uses a programmed calculator known as a HIPP calculator. The calculation involves a comparison of the cost of the premiums of the individual's employer-sponsored insurance with that of the cost of a Medicaid Managed Care plan for that individual, their spouse, and dependent children.

NYSDOH's Third Party Liability Unit maintains all necessary documentation was not received in this case until October 2, 2017 and, therefore, an accurate calculation could not be made until that month ( ). It is the policy of that unit that premium payments will only be made for the first of the month in which all documentation is received in order to accurately enter the information into the HIPP calculator.

On July 12, 2017, NYSOH received a copy of the front and back of your health insurance card ( ). On July 21, 2017, NYSDOH sent you a second Request for Additional Information stating you needed to provide a copy of the front and back of your health insurance card ***and*** a copy of current paystubs showing the insurance premium deduction or a form DOH-5106 filled out by our employer ( ).

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).

On September 19, 2017, NYSDOH issued a notice stating it was unable to determine if your household qualified for Medicaid payment of third party health insurance premiums because a copy of a current paystub showing the insurance premium deduction or Form DOH-5106 filled out by your employer was not provided ([redacted]).

You testified your Navigator provided this after you went to them in late September 2017 or October 2017, you were not sure. The record supports NYSOH received Form DOH-5106 on October 2, 2017, as an upload to your account ([redacted]).

The requests for additional information were mailed to your correct address and you testified you receive notices from NYSOH through regular U.S. Mail. None of the issued notices have been returned to NYSOH as undeliverable as shown in your NYSOH account. Therefore, it is determined NYSOH and NYSDOH provided you proper notice of the need to provide missing documentation so that your request for premium assistance could be processed.

Eligibility for reimbursement of cost-effective third-party health insurance is determined for the month of application and subsequent months only, according to NYSDOH policy. Therefore, premium reimbursement for months prior to the completed October 2017 application are not permitted.

Since the record shows NYSOH provided proper notice of the need for more information to complete a HIPP calculation and that the necessary information was not received until October 2, 2017, NYSOH's October 10, 2017 eligibility notice stating your household was eligible for Medicaid Premium Assistance Program payments, effective October 1, 2017, is AFFIRMED.

Decision

Your request for full premium assistance through NYSOH for the months of May 2017, June 2017, July 2017, and August 2017, is DISMISSED as non-appealable.

The October 10, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 20, 2018

How this Decision Affects Your Eligibility

Your household was eligible for participation in the Medicaid Premium Assistance Program through NYSOH, effective October 1, 2017.

Your household was not eligible for premium assistance through NYSOH for the month of September 2017.

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

Your request for full premium assistance through NYSOH for the months of May 2017, June 2017, July 2017, and August 2017, is DISMISSED as non-appealable.

The October 10, 2017 eligibility determination notice is AFFIRMED.

Your household was eligible for participation in the Medicaid Premium Assistance Program through NYSOH, effective October 1, 2017.

Your household was not eligible for premium assistance through NYSOH for the month of September 2017.

Legal Authority

We are sending you this notice 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.

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).