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

# Notice of Decision

Decision Date: March 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026039

[redacted]

Dear [redacted],

On February 21, 2017 you appeared by telephone at a hearing on your appeal of NY State of Health's December 20, 2017 plan enrollment and eligibility determination notices.

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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DEPARTMENT OF HEALTH
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# Decision

Decision Date: March 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026039

[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 your eligibility for and enrollment in your Essential Plan with a $20.00 monthly premium was effective February 1, 2018?
>
> Did NYSOH properly determine that you were not eligible for Medicaid for the month of November 2017?

## Procedural History

On May 15, 2017, you applied for financial assistance with health insurance. No health plan was selected for enrollment.

On May 16, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a $20.00 monthly premium, effective June 1, 2017.

On December 19, 2017, you updated your application for financial assistance with health insurance. In that application, you indicated that you were seeking help paying for medical bills for the month of November 2017.

That day, a preliminary eligibility determination was prepared. It stated that you were eligible for, and enrolled in, an Essential Plan with a $20.00 monthly

premium, beginning February 1, 2018. It also stated that you were not eligible for help paying medical bills for the month of November 2017.

Also on December 19, 2017, you spoke to NYSOH's Account Review Unit. You appealed the start date of your enrollment in your Essential Plan because it did not start on November 1, 2017. You also appealed the denial of your request for help paying medical bills for the month of November 2017.

On December 20, 2017, NYSOH issued three notices:

1)An eligibility determination notice, based on your December 19, 2017 application, stating that you were eligible for the Essential Plan with a $20.00 monthly premium, effective February 1, 2018;

2)A plan enrollment notice confirming your enrollment in a health plan, with a start date of February 1, 2018; and,

3)A notice of retroactive Medicaid denying your request for help with paying medical bills for the month of November 2017.

On February 21, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until March 7, 2018, to allow you to submit supporting documents.

As of March 8, 2018, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

## Findings of Fact

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

1) You testified that you are seeking enrollment in your health plan to begin on November 1, 2017, because you were eligible for the Essential Plan during that month.

2) According to your NYSOH account and your testimony, you were first determined eligible for the Essential Plan on May 15, 2017, with an effective date of June 1, 2017.

3) According to your NYSOH account, no plan was selected on or after May 15, 2017.

4) You testified that you do not recall selecting a plan for enrollment. You testified that you knew you were not enrolled in a health plan because you

did not receive a notice from NYSOH stating you were enrolled, but that you never followed up with NYSOH.

5) According to your NYSOH account and your testimony, you submitted another application for health insurance on December 19, 2018, and selected a plan for enrollment that date. Your eligibility for the Essential Plan, and enrollment in a health plan, both began February 1, 2018.

6) You testified that you are seeking help paying your medical bills through Medicaid that you incurred in the month of November 2017.

7) The application submitted on December 19, 2017, states that your gross monthly income for November 2017 was $1,833.33.

8) You testified that this is incorrect. You testified that you are paid weekly, and your income varies each week depending on the number of hours you are able to work.

9) You testified that you expect to file your taxes with a filing status of single, and that you will not claim any dependents on that tax return.

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/downloads/ny-blueprint.pdf).

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 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 $1,005.00 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 your enrollment in your Essential Plan with a $20.00 monthly premium was effective February 1, 2018.

You testified, and the record indicates, that you were originally found eligible for the Essential Plan effective June 1, 2017, but that you did not select a health plan for enrollment at that time. You also testified that you knew you were not enrolled in a health plan because you did not receive a notice from NYSOH confirming your enrollment in a health plan, and you did not follow up with them.

You testified, and the record indicates, that you updated your application for health insurance with NYSOH on December 19, 2017. You were found eligible for the Essential Plan as of February 1, 2018, and you selected a health plan for enrollment that also went into effect February 1, 2018.

You testified that you would like the start date of your health plan to begin on November 1, 2017, since you were originally found eligible for the Essential Plan on June 1, 2017.

The date on which enrollment in a health plan can take effect depends on the day a person selects a plan for enrollment, regardless of when a person's eligibility for health insurance begins.

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.

The credible evidence of record shows that you first selected a health plan on December 19, 2017. As such, your enrollment properly took effect on the first day of the second month following December 2017; that is, on February 1, 2018.

Therefore, the December 20, 2017 plan enrollment notice stating that your enrollment in the Essential Plan was effective February 1, 2018, is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for the month of November 2017.

You submitted an application for financial assistance on December 19, 2017. In that application you requested Medicaid coverage for the month of November 2017 for help paying medical bills you received during that month.

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.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You are in a one-person household for purposes of this analysis because you file your taxes with a tax filing status of single, and you do not claim any dependents on your tax return. Therefore, to be eligible for Medicaid in November 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.

In the application you submitted on December 19, 2017, you indicated that your gross income for the month of November 2017 was $1,833.33. NYSOH relied upon this information when it issued the December 20, 2017 notice of retroactive Medicaid. Since a gross monthly income of $1,833.33 is more than the $1,387.00

monthly Medicaid limit for November 2017, NYSOH determined that you were not eligible for Medicaid for the month of November 2017.

However, you testified that in November 2017, you earned less than $1,833.33 and you believe you were eligible for Medicaid during that month.

In order to determine your eligibility for Medicaid retroactively for this month, NYSOH is required to verify the income you received in November 2017. To this end, the Hearing Officer allowed you time to submit income documentation showing the income you received in the month of November 2017. As of the close of the record, no documentation was received that would allow for an analysis of your monthly income and eligibility for those months.

Since no documentation was submitted to show the income you received in the month of November 2017, there is insufficient evidence in the record to conclude that your income was less than the $1,387.00 monthly Medicaid limit.

Therefore, the December 20, 2017 notice of retroactive Medicaid denying your request for help with paying medical bills for the month of November 2017, is correct and is AFFIRMED.

## Decision

The December 20, 2017 plan enrollment notice is AFFIRMED.

The December 20, 2017 notice of retroactive Medicaid is AFFIRMED.

## Effective Date of this Decision: March 16, 2018

## How this Decision Affects Your Eligibility

This decision does not change your eligibility.

Your enrollment in your Essential Plan begins February 1, 2018.

You are not eligible for Medicaid to help with paying medical bills for the month of November 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

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).

## Summary

The December 20, 2017 plan enrollment notice is AFFIRMED.

The December 20, 2017 notice of retroactive Medicaid is AFFIRMED.

This decision does not change your eligibility.

Your enrollment in your Essential Plan begins February 1, 2018.

You are not eligible for Medicaid to help with paying medical bills for the month of November 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.

**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.

**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.

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