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

# Notice of Decision

Decision Date: July 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016912

[redacted]

Dear [redacted],

On July 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 17, 2017 eligibility determination.

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: July 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016912

[redacted]

## Issue

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

> Did NY State of Health (NYSOH) properly determine that you were not eligible to enroll in coverage through NYSOH as of your March 16, 2017 application?

## Procedural History

On January 4, 2016, you filed an updated application for health insurance through NYSOH and uploaded a copy of your I-766 Employment Authorization Card reflecting a category code of "[redacted]." This document was reviewed and verified on January 14, 2016 as valid proof of your immigration status.

On March 10, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective March 1, 2016. You were subsequently enrolled into a Medicaid Managed Care plan.

On February 17, 2017, NYSOH issued a notice of eligibility determination stating that you were no longer eligible to enroll in coverage through NYSOH because you had failed to renew your application for health insurance. This was effective March 1, 2017.

Also on February 17, 2017, NYSOH issued a notice of disenrollment stating that your enrollment in your Medicaid Managed Care plan was ending, effective February 28, 2017.

On March 16, 2017, NYSOH received your updated application for health insurance. That same day, NYSOH prepared a preliminary eligibility determination stating that you were not eligible to purchase health insurance through NYSOH.

Also on March 16, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal, insofar as you were not eligible for coverage in the Essential Plan or Medicaid. You also requested Aid to Continue, pending the outcome of your appeal.

On March 17, 2017, NYSOH issued a determination notice based on your March 16, 2017 application. The notice stated that you were not eligible for Medicaid, Child Health Plus, Essential plan, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. The notice also stated that you were not eligible to enroll in a qualified health plan at full cost. The notice stated that you were ineligible for Medicaid because the household income you provided of $19,000.00 is over the allowable income limit of $16,643.00.

On March 22, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid for a limited time, effective March 1, 2017. This was because NYSOH granted your request for Aid to Continue, pending the outcome of your appeal.

Also on March 22, 2017, NYSOH issued a notice of enrollment confirmation confirming your enrollment in your previous Medicaid Managed Care plan, beginning March 1, 2017. This was also pursuant to your request for Aid to Continue.

On July 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open through July 21, 2017, to allow you to submit supporting documents.

Also on July 6, 2017, you uploaded documentation to your NYSOH account. The record is now closed.

## Findings of Fact

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

1) Your NYSOH account reflects that you expect to file your 2017 taxes with a status of single and you will claim no dependents on that tax return.

2) Your application states you are an immigrant non-citizen.

3) You uploaded a copy of your Employment Authorization card on January 4, 2016 with the status of [redacted], which was verified on January 14, 2016 (Document [redacted]).

4) You uploaded a renewed Employment Authorization Card on June 15, 2017 which also shows a status of [redacted] (Document [redacted]).

5) The status of [redacted], according to the United States Customs and Immigration Services (USCIS) and Social Security Administration (SSA) is in reference to a status classified as Deferred Action on Childhood Arrivals.

6) The application that was submitted on March 15, 2017, which requested financial assistance, listed annual household income of $19,000.00, consisting of income you earn from employment. You testified that you actually expect your 2017 earnings to be closer to $18,000.00.

7) You testified that you work eight hours a day for $7.70 an hour, and that you work 40 hours per week. You testified that you are paid biweekly.

8) After the hearing, you provided documentation of your June 2017 income. You uploaded two paystubs for the following dates and gross earnings:

   a. June 16, 2017 - $720.00;
   b. June 30, 2017 - $800.00;

   (Document [redacted]). This document is marked and entered into the record as "Appellant's [redacted]."

9) You testified that you were told that you were eligible for Essential Plan coverage, and that you thought the issue with your eligibility was resolved once you provided your updated Employment Authorization card.

10) You testified that you are looking to be eligible for the Essential Plan or Medicaid.

11) Your application states that you live 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

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

Qualified Immigrants Transitioned to the Essential Plan

In New York State, qualified immigrants who were formerly eligible for Medicaid through the state, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of January 1, 2016 (New York's Basic Health Plan Blueprint, p. 19, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html). This category of qualified immigrants includes individuals lawfully admitted for permanent residence in the United States who are still in their first five years of permanent residency (18 NYCRR § 349.3, 8 USC § 1613).

Medicaid

A person who meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard is eligible for Medicaid benefits (45 CFR § 155.305(c)). One of the non-financial criteria for Medicaid eligibility is the immigration status of the person applying for health insurance. A person is eligible for Medicaid when his or her immigration status is satisfactory and he or she meets all other requirements for Medicaid.

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 (NY SSL) § 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 Federal Register 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).

Immigration Status

Generally, no person except a United States citizen, a naturalized citizen, a qualified alien, and persons permanently residing in the United States under color of law ([redacted]), is eligible for medical assistance from the state (NY SSL § 122(1); 18 NYCRR § 360-3.2(j)).

A [redacted] alien is a person who is residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure from the United States such agency does not contemplate enforcing (18 NYCRR §360-3.2(j)). The New York Department of Health regards aliens who have been issued an Employment Authorization Document (I-688B or I-766), and have the requisite category code, to be PRUCOL (08 OHIP/INF-4, dated August 4, 2008)).

The guide, "'Key to I-766/I-688B, Employment Authorization Documents (EADs)', defines certain codes on the USCIS Employment Authorization Documents" (08 MA/033, dated December 1, 2008, and as amended). It confirms that a person who has category code of "(c)(33)" has [redacted] status for Medicaid and Child Health Plus only (i*d*.).

## Legal Analysis

The only issue under review is whether NYSOH properly determined that you were not eligible to enroll in coverage through NYSOH as of March 16, 2017.

On January 4, 2016, you provided to NYSOH a copy of your I-766 EAC.

Your employment authorization documentation states you are an immigrant non-citizen with a [redacted] status. The status of [redacted], according to the United States Customs and Immigration Services (USCIS) and Social Security Administration (SSA) is in reference to a status classified as Deferred Action on Childhood Arrivals. Individuals who have obtained an Employment Authorization card with the status of [redacted] are persons considered not "lawfully present," for purposes of

the federal definition of this term, and are therefore not recognized as eligible to receive federal funding under programs requiring lawful presence.

In addition, while individuals who have been determined to be qualified aliens and who were formerly eligible for Medicaid through the state, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of January 1, 2016, this is not the case for persons with Deferred Action status.

Therefore, NYSOH was correct in finding you not eligible for coverage under the Essential Plan.

However, NY State has consistently recognized persons with Deferred Action status to be within the accepted meaning of "[redacted]," even though the federal government has not. The New York Court of Appeals ruled, in *Aliessa, et al. v. Novello* (96 NY 2d 418 [2001]), that New York must provide state-funded Medicaid to the lawfully residing immigrants who had been excluded from access to the federal Medicaid program.

Since your current Deferred Action status does confer PRUCOL status for individuals seeking Medicaid eligibility, we may review whether you met the financial criteria for Medicaid.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size. On the date of your applications, the relevant FPL was $12,060.00 for a one-person household. Since $19,000.00 is 157.55% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Financial eligibility for Medicaid can also be based on current monthly household income and family size.

After the hearing, you submitted two paystubs from the month of June 2017 dated June 16, 2017 and June 30, 2017. You testified that you are paid biweekly; therefore, you should also have submitted a paystub from June 2, 2017. However, even without this missing paystub, your gross income for June 2017 is $1,520.00.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,386.90 per month.

Since the documentation you provided shows that you earned at least $1,520.00 in June 2017, you do not qualify for Medicaid on the basis of monthly income.

Accordingly, the March 17, 2017 eligibility determination notice properly found you to be ineligible for the Essential Plan, as you are not lawfully present for the purposes of that program. However, your ineligibility for Medicaid is properly based on your annual household income being over the limit for that program, not your legal presence.

## Decision

The March 17, 2017 eligibility determination is AFFIRMED.

## Effective Date of this Decision: July 20, 2017

## How this Decision Affects Your Eligibility

You are not eligible for the Essential Plan because you are not lawfully present in the United States for purposes of that program.

Although you qualify as a [redacted] alien for state-based Medicaid, you are not eligible for Medicaid at this time because your household income is over the maximum allowable income limit.

## 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 March 17, 2017 eligibility determination is AFFIRMED.

You are not eligible for the Essential Plan because you are not lawfully present in the United States for purposes of that program.

Although you qualify as a [redacted] alien for state-based Medicaid, you are not eligible for Medicaid at this time because your household income is over the maximum allowable income limit.

## Legal Authority

We are issuing this determination in accordance with 45 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).

## 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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