



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

Notice of Decision

Decision Date: July 14, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016931

[REDACTED]

Dear [REDACTED]

On June 30, 2017, you and your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's March 8, 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 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: July 14, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016931

[REDACTED]

Issues

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

Did NY State of Health properly determine that you were not eligible for the Essential Plan?

Did NY State of Health properly determine that you were not eligible for Medicaid?

Did NY State of Health properly determine that you were not eligible to enroll in a qualified health plan?

Did NY State of Health properly determine that you were not eligible for advance premium tax credits and cost-sharing reductions?

Procedural History

On March 8, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating that you do not qualify for Medicaid, the Essential Plan, advance premium tax credits or cost-sharing reductions, or eligible to purchase a qualified health plan.

On March 16, 2017, NYSOH's Account Review Unit received your written request for an appeal of that eligibility determination insofar as you were not found eligible for health insurance through NYSOH.

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 June 29, 2017, you were scheduled to have a hearing with a Hearing Officer from NYSOH's Appeals Unit. You requested that the hearing be adjourned to the following day. Your request was granted.

On June 30, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you appointed your [REDACTED] [REDACTED] [REDACTED] as your authorized representative. 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) Your authorized representative testified that you are a widow and expect to file your 2017 tax return as single. Your application indicates that you will claim no dependents.
- 2) You are seeking insurance coverage for yourself.
- 3) The application that was submitted on March 7, 2017, which requested financial assistance, listed annual household income of \$15,000.00. You testified that this amount was correct.
- 4) The record supports that you are [REDACTED].
- 5) Your application indicates that you have a citizenship/immigration status of "other".
- 6) You uploaded a copy of your I-766 card which lists a category code of [REDACTED]. The card states that it is valid from March 1, 2017 through February 28, 2018.
- 7) U.S. Citizenship and Immigration Services states that a category code of [REDACTED] is "pending adjustment of status under Section 245 of the Act."
- 8) You testified that you entered the country in 1998.
- 9) You testified that you applied for a green card and are currently awaiting a decision on that application.
- 10) You reside in [REDACTED]
- 11) You testified that you have not applied for coverage through your Local Department of Social Services.

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

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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 general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (see N.Y. Soc. Serv. Law § 366(1)(c)).

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).

Advance Payments of the Premium Tax Credit:

Advance payments of the premium tax credit (APTC) are available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the applicable FPL, (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (see 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR § 155.300(a), 45 CFR § 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is \$16,020.00 for a two-person household (81 Fed. Reg. 4036).

Qualified Health Plan

To enroll in a qualified health plan (QHP) through NYSOH, an applicant must be a citizen or national of the United States or a non-citizen who is lawfully present in the United States and reasonably expects to become a citizen or remain a lawfully present noncitizen for the entire period for which enrollment is being sought (45 CFR § 155.305(a)(1)).

Lawful Presence

Lawfully present means, a qualified alien as defined in section 431 of the Personal Responsibility and Work Opportunity Act.

A qualified alien as defined by the Personal Responsibility and Work Opportunity Act means, an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act. See (45 CFR §152.2 (1)), (8 U.S. Code §1641 (b)(1)).

Cost-Sharing Reductions:

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive advanced premium tax credits, (3) is expected to have an annual household income that does not exceed 250% of the applicable FPL for the plan year for which coverage is requested, (4) is enrolled in a silver-level QHP (45 CFR § 155.305(g)(1)).

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 (PRUCOL), is eligible for medical assistance from the state (NY Soc. Serv. Law § 122(1); 18 NYCRR § 360-3.2(j)).

A PRUCOL 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)(9)” has PRUCOL status for Medicaid and Child Health Plus only (*id.*).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan.

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The Essential Plan is provided through NYSOH to individuals who are lawfully present non-citizens who are ineligible for Medicaid or Child Health Plus as a result of their immigration status, and have a household income that is between 0% and 200% of the Federal Poverty Level (FPL), and must be 64 years old or younger.

The application that was submitted on March 7, 2017 stated that you were [REDACTED].

Since you were over the age of [REDACTED] you are not eligible for the Essential Plan through NYSOH.

The second issue is whether NYSOH properly determined that you were not eligible for Medicaid.

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 that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$12,060.00 for a one-person household.

The application that was submitted on March 7, 2017, which requested financial assistance, listed annual household income of \$15,000.00. You testified that this amount was correct. Your authorized representative testified that you are a widow and expect to file your 2017 tax return as single. Your application indicates that you will claim no dependents.

Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives.

According to your testimony and the information in your NYSOH application, you have no dependents, therefore, you are not a parent or a caretaker relative of a dependent child.

At the time NYSOH issued the March 8, 2017 eligibility determination you were [REDACTED].

Since you are over the allowable age limit for MAGI-based Medicaid, and are not a parent or caretaker relative, NYSOH properly determined that you are not eligible for Medicaid through NYSOH.

The third issue is whether NYSOH properly determined that you were not eligible to enroll in a qualified health plan.

Federal regulations require that a person seeking enrollment in a qualified health plan through the NYSOH have United States citizenship or satisfactory immigration status. Your application indicates that you have a citizenship/immigration status of "other". You uploaded a copy of your I-766 card which lists a category code of [REDACTED]. U.S. Citizenship and Immigration Services states that a category code of [REDACTED] is "pending adjustment of status under Section 245 of the Act." Under federal regulations, a person pending adjustment of status does not qualify to enroll into a qualified health plan.

The fourth issue is whether NYSOH properly determined that you were not eligible for advance premium tax credits and cost-sharing reductions.

The application that was submitted on March 7, 2017 listed an annual household income of \$15,000.00 and the eligibility determination relied upon that information.

You are in a one-person household since you expect to file your 2017 tax return as single and claim no tax dependents.

Advance premium tax credits are available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the applicable FPL, (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market.

As stated above, you are not eligible to enroll into a qualified health plan due to your current immigration status. Furthermore, your household income is below 138% of the FPL, and therefore you would not qualify for tax credits through NYSOH. In order to be eligible for cost-sharing reductions, a person must also be eligible for advance premium tax credits.

Since the March 8, 2017 eligibility determination notice properly found you ineligible for the Essential Plan, Medicaid, advance premium tax credits, cost-sharing reductions and ineligible to enroll into a qualified health plan, it is correct and is AFFIRMED.

NYSOH does not have the authority to determine whether or not you qualify for non-MAGI-based Medicaid. That authority lies with the Local Department of Social Services.

During the hearing, you testified that you have not applied for non-MAGI-based Medicaid through your Local Department of Social Services. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to the Local Department of Social Services for consideration.

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).

Decision

The March 8, 2017 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to refer you to Local Department of Social Services for a determination of your eligibility for Non-MAGI Medicaid.

Effective Date of this Decision: July 14, 2017

How this Decision Affects Your Eligibility

You remain ineligible for the Essential Plan.

You remain ineligible for MAGI based Medicaid.

You are ineligible for advance premium tax credits.

You are ineligible for cost-sharing reductions.

You are ineligible to enroll in a qualified health plan.

Your case is being sent to the Local Department of Social Services to see if you qualify for Medicaid on a different basis.

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)).

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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 8, 2017 eligibility determination is **AFFIRMED**.

You remain ineligible for the Essential Plan.

You remain ineligible for MAGI based Medicaid.

You are ineligible for advance premium tax credits.

You are ineligible for cost-sharing reductions.

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 are ineligible to enroll in a qualified health plan.

Your case is RETURNED to NYSOH to refer you to Local Department of Social Services for a determination of your eligibility for Non-MAGI Medicaid.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:



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)

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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।

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 नि:शुल्क 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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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 איר געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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