

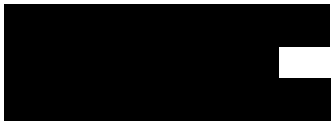


STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: December 12, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022200



On November 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 6, 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: December 12, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022200



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 ineligible for Medicaid?

Did NY State of Health properly determine that you were ineligible for the Essential Plan, advance payment of the premium tax credit and cost-sharing reductions, or to enroll in a qualified health plan at full cost?

Procedural History

On September 5, 2017, you updated your application for financial assistance with health insurance.

On September 6, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were not eligible for Medicaid. This was because your income was over the allowable income limit for that program. The notice stated that you were not eligible for the Essential Plan, to receive advance payment of the premium tax credit and cost-sharing reductions, or to enroll in a qualified health plan at full cost. This was because NYSOH was unable to verify your citizenship or immigration status.

Also on September 6, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not eligible for financial assistance or to enroll in 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 November 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for fourteen days to allow you time to submit supporting documents, specifically, the Hearing Officer requested that you produce your visa, your spouse's visa, and your spouse's paystubs for September 2017.

On November 27, 2017, the Appeals Unit received via fax a copy of your spouse's I-797A Notice of Action on his petition for a nonimmigrant worker, your visa issued August 11, 2016, and five of your spouse's paystubs. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

Findings of Fact

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

- 1) You testified that you expect to file your 2017 tax return with a tax filing status of married filing jointly. You will claim one dependent on that tax return.
- 2) The application that was submitted on September 5, 2017 listed annual household income of \$44,252.00, consisting of wages your spouse earns from his employment. You testified that this amount was correct.
- 3) The application that was submitted on September 5, 2017 lists your citizenship/immigration status as "other".
- 4) You testified that you have had no income in 2017.
- 5) You testified that in September 2017 your spouse received \$3,450.00 in income.
- 6) Your application states, and you confirmed, that you will not be claiming any deductions on your 2017 tax return.
- 7) You testified that you reside at [REDACTED].
- 8) You testified that you have been present in the United States on an H-4 visa since September 2016, and are therefore, not eligible for a social security number. You testified that your spouse has an [REDACTED] which allows him to work, and that he has been assigned a social security number.
- 9) You submitted a copy of your [REDACTED] was issued on August 11, 2016 and is valid until September 21, 2018.

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- 10) You submitted a copy of your spouse's [REDACTED] indicates that his request for an [REDACTED] granted from September 22, 2015 through September 21, 2018.
- 11) You submitted five of your spouse's paystubs; the first is for pay date June 16, 2017; the second is for pay date June 23, 2017; the third is for pay date June 30, 2017; the fourth is for pay date July 7, 2017; the fifth is for pay date July 14, 2017 and shows a year to date gross pay amount of \$37,268.13.
- 12) You testified that you are seeking to be able to enroll in health insurance and would like financial assistance with your health insurance.

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

Applicable Law and Regulations

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 § 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 \$20,420.00 for a three-person household (82 Fed. Reg. 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).

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).

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).

Lawfully present immigrants who are eligible for Essential Plan include qualified aliens in the five-year ban, persons Permanently Residing Under Color of Law (PRUCOL) and temporary non-immigrants meeting residency requirements (45 CFR § 152.2(2) and (4)(i); 16 OHIP/ADM-01 (01/20/2016)). Immigrants who are pregnant or are under 21 years of age, and are in the first five years of their qualified status or are PRUCOL, are eligible for federal financial participation and, therefore, are not eligible for Essential Plan and will remain in Medicaid (*id.*).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is \$20,160.00 for a three-person household (80 Federal Register 3236, 3237).

Advance Payments of Premium Tax Credit

Advance payments of the premium tax credit (APTC) are generally available to a tax filer who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (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 QHP, 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)).

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 APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for

which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Qualified Health Plan

To enroll in a qualified health plan (QHP) through the Marketplace, 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)).

NYSOH must verify or obtain information in order to determine that an applicant is eligible for enrollment in a qualified health plan, including the certification of citizenship, status as a national, or lawful presence (45 CFR § 155.315(a), (c)).

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)).

Lawfully present is defined to mean (1) A qualified alien as defined in section 431 of the Personal Responsibility and Work Opportunity Act (PRWORA) (8 United States Code (USC) §1641): or (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission (45 CFR § 152.2).

An H-4 visa is a visa given to the spouse or child of an alien who is coming temporarily to the United States to perform services in a specialty occupation for an employer who has been granted a visa pursuant to the Immigration and Nationality Act ((8 USC §1641(b); 8 USC § 1101(a)(15)(H(iv))). Individuals with these statuses qualify to enroll through NYSOH.

State Residency Requirement

To be eligible for enrollment in a qualified health plan and eligible to receive an advance premium tax credit through NYSOH, an applicant must be a resident of New York State (45 CFR § 155.305(a)(3), (f)(1)(ii)(A)).

For an individual who is aged 21 or older, not living in an institution, and able to indicate intent, that individual is deemed to be a resident of the Exchange service area in which or she lives and either a) intends to reside, even without a fixed address, or b) has entered with a job commitment or is seeking employment. (45 CFR § 155.305(a)(3)(i)).

Temporary non-immigrants will be required as a condition of their eligibility to answer residency questions. An applicant must answer "Yes" to at least one of the questions in order to pass residency review (Office of Health Insurance Programs, GIS 16 MA/02). These questions include have you applied to become a legal permanent resident; do you work; do your children go to school; do you own your own home, do you rent a house or apartment.

Legal Analysis

The first issue is whether NYSOH properly determined that you were ineligible for Medicaid.

The application that was submitted on September 5, 2017 listed an annual household income of \$44,252.00 and the eligibility determination relied upon that information.

You expect to file your 2017 income taxes as married filing jointly and will claim one dependent 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 that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$20,420.00 for a three-person household. Since \$44,252.00 is 216.71% 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.

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

You testified that in September 2017 your spouse received \$3,450.00.

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 \$2,349.00 per month. Since the testimony you provided shows that your spouse earned \$3,450.00 in September 2017 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

The second issue is whether NYSOH NY State of Health properly determined that you were ineligible for the Essential Plan, advance payment of the premium tax credit and cost-sharing reductions, or to enroll in a qualified health plan at full cost.

In the application you submitted on September 5, 2017, you indicated that you are not eligible for a social security number due to your immigration status and listed your immigration status as “other”.

As a result of the September 5, 2017 application, you were determined ineligible for the Essential Plan, advance payments of the premium tax credit and cost-sharing reductions, or to enroll in a qualified health plan at full cost.

In order to be eligible for the Essential Plan through NYSOH, an applicant must have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size and must be lawfully present and have a valid immigration or citizenship status. Lawfully present immigrants who are eligible for the Essential Plan include qualified aliens in the five-year ban, persons Permanently Residing Under Color of Law (PRUCOL) and temporary non-immigrants meeting residency requirements.

In order to be eligible for advance payments of the premium tax credit, a tax filer must meet the requirements to enroll in a qualified health plan. In order to be eligible for cost-sharing reductions, a tax filer must be eligible for advance payments of the premium tax credit.

In order to enroll in a qualified health plan through NYSOH, an applicant must be a citizen 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.

As you did not indicate that you were a lawfully present nonimmigrant visa holder, NYSOH properly found that you were ineligible for the Essential Plan, advance payment of the premium tax credit and cost-sharing reductions, or to enroll in a qualified health plan at full cost.

Therefore, the September 5, 2017 notice of eligibility determination is **AFFIRMED**.

However, following the hearing, you submitted a copy of your H-4 visa which was issued August 11, 2016 and which will expire September 21, 2018. Under the Immigration and Nationality Act, [REDACTED] denotes a status of a qualified nonimmigrant visa holder.

Therefore, your case is **RETURNED** to NYSOH to ensure that all the information contained in your NYSOH account is accurate in light of your unexpired visa [REDACTED] and your testimony in regard to your NY state residency and to redetermine your eligibility for financial assistance based on a household of three residing in Suffolk County with an annual household income of \$44,252.00.

Decision

The September 5, 2017 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to ensure that all the information contained in your NYSOH account is accurate in light of your unexpired visa [REDACTED] and your testimony in regard to your NY state residency and to redetermine your eligibility for financial assistance based on a household of three residing in Suffolk County with an annual household income of \$44,252.00.

Effective Date of this Decision: December 12, 2017

How this Decision Affects Your Eligibility

NYSOH properly found you ineligible for Medicaid as you are over the income limit for that program.

NYSOH properly found you ineligible for the Essential Plan, advance payment of the premium tax credit and cost-sharing reductions, or to enroll in a qualified health plan at full cost, as NYSOH could not verify your citizenship or immigration status.

Your case is being sent back to NYSOH to update your account based on the visa you submitted and to redetermine your eligibility for financial assistance.

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 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).

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 September 5, 2017 eligibility determination is AFFIRMED.

NYSOH properly found you ineligible for Medicaid as you are over the income limit for that program.

NYSOH properly found you ineligible for the Essential Plan, advance payment of the premium tax credit and cost-sharing reductions, or to enroll in a qualified health plan at full cost, as NYSOH could not verify your citizenship or immigration status.

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).

Your case is RETURNED to NYSOH to ensure that all the information contained in your NYSOH account is accurate in light of your unexpired visa [REDACTED] and your testimony in regard to your NY state residency and to redetermine your eligibility for financial assistance based on a household of three residing in Suffolk County with an annual household income of \$44,252.00.

Legal Authority

We are issuing this determination 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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi 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 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).