



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

## Notice of Decision

Decision Date: December 8, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022490

[REDACTED]

[REDACTED]

On November 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 19, 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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## Decision

Decision Date: December 8, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022490

[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 NY State of Health as of November 1, 2017?

## Procedural History

On September 18, 2017, NYSOH received your updated application for health insurance. That day, a preliminary eligibility determination was prepared stating that you were not eligible to enroll in health care coverage through NYSOH.

Also on September 18, 2017, you spoke to NYSOH's Account Review Unit and appealed the preliminary eligibility determination, insofar as it stated that you were not eligible to enroll in health insurance through NYSOH.

On September 19, 2017, NYSOH issued an eligibility determination notice based on the September 18, 2017 application stating that you were not eligible for Medicaid because your household income was over the allowable income limit. You were not eligible for 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. This was because your "[v]erification documents show not lawfully present."

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

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open for 15 days, until November 29, 2017, to allow you the opportunity to provide supporting documents.

On November 28, 2017, NYSOH received via fax copies of paystubs from your employment with [REDACTED] and letter from that employer, copies of paystubs from your employment with [REDACTED] and a letter from that employer, and a copy of your payment history and final paystub from [REDACTED]. 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) The record 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) You are seeking insurance for yourself.
- 3) Your application states you are an immigrant non-citizen.
- 4) You uploaded a copy of your Employment Authorization card on September 18, 2017 with the status of C-33, which was verified that same day.
- 5) The status of C-33, 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) You testified that you are present in the United States under the status of DACA. You have had DACA status since 2015, and that you submitted a renewal application for continued DACA status in August 2017.
- 7) The application that was submitted on September 18, 2017, which requested financial assistance, listed annual household income of \$16,650.40, consisting of income you earn from employment.
- 8) You testified that this amount is incorrect because you are a student, you work inconsistent hours based on your school schedule, and that your employers changed.
- 9) You testified that in 2017, you worked for [REDACTED]

- 10) You testified that you stopped working at [REDACTED] in May 2017, but that in September 2017 you were employed at [REDACTED]
- 11) You provided paystubs that show your total gross income for September 2017 was \$1,152.61, consisting \$227.85 in gross earnings from [REDACTED] and \$974.76 in gross earnings [REDACTED]
- 12) 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

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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 \$12,060.00 for a one-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).

### 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)).

### 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

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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 PRUCOL status for Medicaid and Child Health Plus only (*id.*).

## **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 November 2, 2017.

On September 19, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible to enroll in the Essential Plan because you are not considered lawfully present.

On September 18, 2017, you provided to NYSOH a copy of your I-766 EAC. That same day, this information was verified and an application was submitted to NYSOH on your behalf. That application listed an annual household income of \$16,650.40, and reflected that you were an immigrant non-citizen.

As a result, NYSOH issued an eligibility determination notice stating that you were not qualified to enroll in coverage through NYSOH because the documentation you provided showed that you were not lawfully present.

Your employment authorization documentation states you are an immigrant non-citizen with a C-33 status. The status of C-33, 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 C-33 category are persons considered not “lawfully present” for purposes of the federal definition, and are therefore not recognized as eligible to receive federal funding under those programs.

In addition, while individuals who have been determined to be qualified aliens and 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 who received 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 within the accepted meaning of “*PRUCOL alien*”; 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. NYSOH relied upon the income listed in your application, \$16,650.40, in determining your Medicaid eligibility. Since \$16,650.40 is 138.06% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, based on the information provided in your application.

Finally, federal regulations require that a person seeking enrollment in a qualified health plan through NYSOH have United States citizenship or satisfactory or immigration status. Under the federal regulations, individuals with Deferred Action for Childhood Arrivals status are not considered to be lawfully present for the purposes of obtaining coverage in a qualified health plan through NYSOH.

Accordingly, the September 19, 2017 eligibility determination notice is AFFIRMED because it properly found you to be ineligible for the Essential Plan or qualified health plan based on you not being lawfully present. Your ineligibility for Medicaid was properly based on your annual household income listed on your application being over the limit for that program.

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

You testified, and [REDACTED] You submitted paystubs that your gross income from your employment at [REDACTED] September 2017 was \$227.85. You also submitted paystubs that show your gross income from your employment [REDACTED] September 2017 was \$924.76. Therefore, the evidence in the record establishes that your total gross income for September 2017 was \$1,152.61.

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Since the record now contains a more accurate representation of what your income was for the month of September 2017, your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid on a monthly income basis based on a household size of one person and household income of \$1,152.61 for the month of September 2017.

## **Decision**

The September 19, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid on a monthly income basis based on a household size of one person and household income of \$1,152.61 for the month of September 2017.

**Effective Date of this Decision:** December 8, 2017

## **How this Decision Affects Your Eligibility**

This is not a final determination of your eligibility for Medicaid. Your case is being sent back to NYSOH to redetermine your eligibility based on the information you submitted during your hearing.

## **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:

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).

- 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 19, 2017 eligibility determination notice is **AFFIRMED**.

Your case is **RETURNED** to NYSOH to redetermine your eligibility for Medicaid on a monthly income basis based on a household size of one person and household income of \$1,152.61 for the month of September 2017.

This is not a final determination of your eligibility for Medicaid. Your case is being sent back to NYSOH to redetermine your eligibility based on the information you submitted during your hearing.

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## **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.

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**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 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 bɛtumi ama wo obi a okyerɛ 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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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