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

Notice of Decision

Decision Date: February 12, 2018

NY State of Health Account ID:
Appeal Identification Number: AP00000024673

On January 29, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 24, 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: February 12, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000024673

Issue

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

> Did NYSOH properly determine that your mother was eligible to enroll in the Essential Plan, with a $20.00 monthly premium, as of October 24, 2017?

Procedural History

On October 23, 2017, you submitted a financial assistance application through NYSOH.

On October 24, 2017, NYSOH issued a notice of eligibility determination, stating in relevant part, that your mother was eligible to enroll in the Essential Plan for a limited time with a $20.00 monthly premium, effective December 1, 2017.

Also on October 24, 2017, NYSOH issued a plan enrollment notice confirming, in relevant part, that as of October 23, 2017, your mother was enrolled in an Essential Plan with an enrollment start date of December 1, 2017.

On November 21, 2017, you contacted NYSOH and requested an appeal relative to the amount of financial assistance your mother was determined eligible to receive.

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On January 29, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing and the record was fully developed. The record closed at the end of the hearing.

Findings of Fact

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

1) You testified that you were only appealing your mother's eligibility determination.

2) According to your NYSOH account, your mother is [redacted] and her marital status is single.

3) According to your NYSOH account and testimony, your mothers resides with you, your spouse, and two children.

4) According to your NYSOH account, you expected to claim your mother as a dependent on your 2017 federal income tax return.

5) According to your NYSOH account, your mother will not be filing a federal income tax return and has an expected yearly income of $0.00.

6) You testified that your mother arrived in the United States in 2015 and was initially issued a permanent resident card on [redacted] 2015.

7) According to your NYSOH account, your mother is an "Immigrant Non-Non-Citizen," and has a permanent resident card with an expiration date of [redacted] 2025.

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

Applicable Law and Regulations

Household Composition

If an individual is claimed as a tax dependent by a tax filer who is not their spouse or parent, their household is contingent on the people they reside with. If living with the individual, the household includes their spouse and their children or stepchildren under the age of 19, or 21 if a full-time student (42 CFR § 435.603(f)(2)(i); 42 CFR § 435.603(f)(3); (New York's Basic Health Plan Blueprint, p. 19, as approved March 2015; see https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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 $12,060.00 for a one-person household (82 Federal Register 8831).

Lawfully Present Non-Citizens Transitioned to the Essential Plan

Lawfully present non-citizens who enter the United States on or after August 22, 1996, are not eligible for the federal Medicaid program for a period of 5 years. The five-year period begins on the date the lawfully-present non-citizen enters the United States. An individual who is lawfully admitted for permanent residence is subject to a five-year ban (8 USC § 1613(a); 8 USC § 1641(b)(1)).

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.

As of January 1, 2016, lawfully present non-citizens who were eligible for state-funded Medicaid, but not eligible for the federal Medicaid program because of their immigration status, were eligible for the Essential Plan. Individuals with incomes less than 100% of the FPL would be enrolled in a plan with no premiums and co-payments (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; 16 OHIP/ADM-01). 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).

Legal Analysis

The issue under review is whether NYSOH properly determined that your mother was eligible to enroll in the Essential Plan with a $20.00 monthly premium, as of October 24, 2017.

The record reflects that you expect to claim your mother as a dependent on your federal income tax return, and your mother does not reside with a spouse or a child under the age of 21. Therefore, your mother is in a one-person household for purposes of this analysis.

In the October 23, 2017 application, you attested that your mother's expected yearly income was $0.00. Based on that attestation, her financial eligibility was determined.

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 October 23, 2017 application, the relevant FPL was $12,060.00 for a one-person household. Since an annual income of $0.00 is 0.00% of the 2017 FPL, your mother met the financial eligibility criteria Medicaid.

Lawfully present immigrants who enter the United States on or after August 22, 1996, are not eligible for the federal Medicaid program for a period of 5 years. An individual who is lawfully admitted for permanent residence is subject to this five-year ban. Lawfully present immigrants, who had been excluded from access to the federal Medicaid program because of their immigration status, must be provided state-funded Medicaid.

Beginning on January 1, 2016, lawfully present immigrants who were financially eligible for Medicaid, but ineligible for federal Medicaid because of their immigrations status, were eligible to enroll in the Essential Plan. Individuals with incomes less than 100% of the FPL were eligible to be enrolled without any premiums or co-payments.

The record reflects that your mother entered the United States in 2015 and has been a permanent resident since [redacted] 2015. Therefore, your mother in within her first five years of permanent residency. Further, as stated above, your mother's expected yearly income is 0.00% of the FPL. Therefore, your mother should be eligible to enroll in the Essential Plan with a monthly premium of $0.00.

The October 24, 2017 eligibility determination notice was proper as to your mother's eligibility for the Essential Plan and is AFFIRMED, but improper as to the amount of monthly premium amount such that this portion of the notice is RESCINDED.

This case is RETURNED to NYSOH to redetermine your mother's premium amount, using a one-person household and an income of $0.00 for an individual within the first five years of permanent residency.

Decision

The October 24, 2017 eligibility determination notice was proper as to your mother's eligibility for the Essential Plan and is AFFIRMED, but improper as to the amount of monthly premium amount such that this portion of the notice is RESCINDED.

This case is RETURNED to NYSOH to redetermine your mother's premium amount, using a one-person household and an income of $0.00 for an individual within the first five years of permanent residency.

Effective Date of this Decision: February 12, 2018

How this Decision Affects Your Eligibility

Your mother was properly determined eligible to enroll in the Essential Plan, but improperly determined to have a $20.00 monthly premium.

Your mother's case is being sent back to NYSOH to redetermine her eligibility for the Essential Plan and premium amount using the information noted above. NYSOH will notify you of its redetermination.

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 October 24, 2017 eligibility determination notice was proper as to your mother's eligibility for the Essential Plan and is AFFIRMED, but improper as to the amount of monthly premium amount such that this portion of the notice is RESCINDED.

This case is RETURNED to NYSOH to redetermine your mother's premium amount, using a one-person household and an income of $0.00 for an individual within the first five years of permanent residency.

Your mother was properly determined eligible to enroll in the Essential Plan, but improperly determined to have a $20.00 monthly premium.

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 mother's case is being sent back to NYSOH to redetermine her eligibility for the Essential Plan and premium amount using the information noted above. NYSOH will notify you of its redetermination.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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।

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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 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 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.

(Urdu)اردو

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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