



**DECISION  
OF AGENCY  
ON APPEAL**

In the Appeal of: [REDACTED]  
For: Advance Payment of Premium Tax Credit  
MinnesotaCare  
Medical Assistance  
Agency: MNsure Board  
Minnesota Department of Human Services  
Docket: 148825

On January 14, 2014 Appeals Examiner Douglass Alvarado held an evidentiary hearing under 42 U.S.C. §18081(f) and Minn. Stat. §62V.05, Subd. 6(a).

The following people appeared at the hearing:

[REDACTED] Appellant  
[REDACTED] Appellant's Spouse  
[REDACTED] MNsure Representative

Based on the evidence in the record and considering the arguments of the parties, I recommend the following findings of fact, conclusions of law, and order.

## STATEMENT OF ISSUE

Whether the MNsure Board correctly denied the Appellant's application for advanced payment of a Premium Tax Credit because the Appellant is eligible for employer-sponsored minimum essential coverage.

Whether the Minnesota Department of Human Services properly denied the Appellant's eligibility for Medical Assistance and MinnesotaCare benefits.

## FINDINGS OF FACT

1. The MNsure Board (herein Agency) advised the Appellant that the Appellant was not eligible for advanced payment of a Premium Tax Credit. *Agency Exhibits # 1 & 2.* The Appellant filed a request challenging this action, which MNsure received on December 17, 2013. On January 14, 2014, the Human Services Judge held an evidentiary hearing via telephone conference. The judge accepted into evidence two exhibits from the Agency<sup>1</sup> and one exhibit from the Appellant<sup>2</sup>. The record was held open until January 22, 2014 for the Appellant to submit additional documentation. On January 15, 2014 the Appellant submitted his 2012 federal income tax return (marked as Appellant's Exhibit B) and an employer-sponsored insurance premium overview for January 1, 2014 to December 31, 2014 (marked as Appellant's Exhibit C). The record was closed on January 22, 2014.

2. On November 19, 2013 the Appellant applied for a health care coverage through MNsure. *Agency Exhibits # 1 & 2.* The Appellant's household consists of the Appellant, his wife, [REDACTED] and his child, [REDACTED] age 18. *Id.* and Appellant's testimony.

3. The Appellant and his wife file taxes jointly and claim [REDACTED] as a dependent. *Appellant's Exhibit B.*

4. The Appellant is eligible for enrollment in a Qualified Health Plan.

5. The Appellant is self-employed as a farmer. His net farm loss for 2012 was -\$25,558.00. *Appellant's Exhibit B.* [REDACTED] attested to anticipated gross income of \$51,825.00 for the tax year. *Agency Exhibit # 2.* [REDACTED] was projected to have

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1 The Agency submitted two exhibits which were marked as follows: 1) State Agency Appeals Summary dated January 9, 2014; and 2) Amended Appeals Summary.

2 The Appellant submitted one exhibit which was marked as follows: A) Appeal Request Form.

income of \$6,500.00. *Id.*

6. [REDACTED] [REDACTED] is employed and is enrolled in self-only employer-sponsored health care insurance coverage through her job. *Agency Exhibit # 2 and testimony of [REDACTED]* [REDACTED] The employee share of self-only employer-sponsored health care coverage is \$150.00 monthly or \$1,800.00 annually. *Appellant's Exhibit C and testimony of [REDACTED]* [REDACTED] The Appellant was eligible for enrollment in his wife's employer-sponsored coverage during the open-enrollment period of December 1, 2013 through December 31, 2013. *Id. and testimony of [REDACTED]* The employee cost of "single + 1" coverage is \$600.00 monthly *Appellant's Exhibit C*. The employee cost of "family" coverage is \$800.00. *Id.*

7. [REDACTED] [REDACTED] employer-sponsored health coverage provides minimum value in that it pays 80 percent of allowable medical expenses with a 20 percent copay after reaching the annual deductible of \$6,000.00. The Appellant's employer pays \$5,000.00 of the annual deductible expenses. *Testimony of [REDACTED]* No other evidence was submitted to establish that this plan does not provide minimum value.

8. [REDACTED] [REDACTED] is in receipt of Medical Assistance benefits. *Testimony of [REDACTED]* and [REDACTED]

9. The Agency calculated the Appellant's anticipated household income based upon the modified adjusted gross income (MAGI) for Appellant's family of \$58,325.01 which consisted of adjusted gross income of \$51,825.00 from [REDACTED] employment, \$.01 from the Appellant's farm income, and \$6,500.00 from [REDACTED] employment. *Agency Exhibits # 1 & 2 and testimony of [REDACTED]* The Appellant was unable to enter a loss of income when applying on the MNsure website. *Testimony of [REDACTED]* There was no foreign income and housing costs excluded under 26 U.S.C. § 911, tax exempt interest or Social Security benefits not included in gross income. *Agency Exhibits # 1 & 2 and testimony of [REDACTED]*

10. The Agency denied Appellant's application for advanced payment of a Premium Tax Credit because the Appellant is eligible for minimum essential coverage through his wife's employer. *Agency Exhibits # 1 & 2 and testimony of [REDACTED]*

11. The Appellant contends that his wife's employer-sponsored insurance for "single + 1" or "family" coverage is not affordable. *Testimony of [REDACTED]*

#### APPLICABLE LAW

12. Pursuant to 45 C.F.R. § 155.520(b)(1) and Minn. R. 770.0105, subp. 2(D) an appeal must be received within 90 days from the date of the notice of eligibility

determination.

13. The MNsure Board has the legal authority to review and decide issues in this appeal regarding Appellant's eligibility through MNsure for Advance Premium Tax Credits, Cost Sharing Reductions, Qualified Health Plan, and/or the Small Business Health Insurance Options Program. *Minn. Stat. § 62V.05, subd. 6*. The MNsure Board has an agreement with the Department of Human Services to hear and decide appeals involving premium assistance. The Commissioner of the Minnesota Department of Human Services has the legal authority to review and decide issues in this appeal regarding Appellant's eligibility for Medical Assistance and MinnesotaCare. *Minn. Stat. § 256.045, subd. 3*.

14. Federal regulations governing Medical Assistance and Exchange appeals require that, if an individual appeals a determination of eligibility for the advance payment of the premium tax credit or cost sharing reductions, the appeal will automatically be treated as a request for a fair hearing of the denial of eligibility of Medicaid.<sup>3</sup> The reason for this automatically pairing of Medicaid appeals with appeals concerning advance payment of the premium tax credits is to further the goal of providing a streamlined, coordinated appeals process for appellants which avoids the need for the appellant to file multiple appeals with different agencies. *Id.* In Minnesota, Medicaid programs include Medical Assistance and MinnesotaCare.

15. Federal regulations concerning eligibility for advanced payment of a Premium Tax Credit (APTC) are found at 45 C.F.R. §155.305(f)(1) and 26 C.F.R. §1.36B-2. MNsure must determine a tax filer eligible for a APTC if he or she is expected to have Modified Adjusted Gross Income (MAGI) between 100% and 400% of federal poverty guidelines during the benefit year for which coverage is requested (unless he or she is a lawfully present noncitizen), and one or more applicants claim a personal exemption deduction on their federal tax return for the benefit year, are eligible for enrollment in a Qualified Health Plan, and are not eligible for minimum essential coverage.

16. "Household income" means the sum of a taxpayer's modified adjusted gross income plus the aggregate modified adjusted gross income of all other individuals who are included in the taxpayer's family and are required to file a tax return for the taxable year<sup>4</sup>. 26 C.F.R. §1.36B-1(e)(1). "Modified adjusted gross income" (MAGI) means adjusted gross income increased by: (i) amounts excluded from gross income under 26 U.S.C. §911 (foreign income and housing costs); (ii) tax exempt interest the taxpayer

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<sup>3</sup> 45 C.F.R. § 155.510(b)(3); 78 Fed. Reg. 4598 (proposed Jan. 22, 2013)(comments regarding proposed 42 C.F.R. § 431.221(e)); and 78 Fed. Reg. 54096 (Aug. 30, 2013)(comments regarding 45 C.F.R. § 155.510(b)(3)).

<sup>4</sup> 26 U.S.C. § 1 sets forth those individuals who must file a tax return. Pursuant to 26 U.S.C. § 1(c) unmarried individuals (other than a surviving spouse or head of a household) must file a return if taxable income is over \$22,100.

receives or accrues during the taxable year; and (iii) social security benefits not included in gross income under 26 U.S.C. § 86. 26 C.F.R. §1.36B-1(e)(2). Losses incurred in a trade or business during the taxable year which are not compensated for by insurance or otherwise are allowed as a deduction from income. 26 U.S.C. § 165(a)-(c). 26 U.S.C. § 162 authorizes the deduction from gross income of all ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business.

17. Minimum essential coverage is defined in 26 C.F.R. § 136B-2(c) and 26 U.S.C. § 5000A(f)(1) as coverage which is: 1) government sponsored; 2) employer sponsored; 3) a health plan offered in the individual market within a State; 4) a grandfathered health plan; or 5) other health benefits coverage. The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is either a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or any other plan or coverage offered in the small or large group market within a State and includes a grandfathered health plan described in paragraph (1)(D) offered in a group market. 26 U.S.C. § 5000A(f)(2).

18. Employer-sponsored minimum essential coverage must be affordable and provide minimum value. 26 C.F.R. § 1.36B-2(c)(3)(i). An employee or an individual who may enroll in the employer-sponsored plan is considered eligible for minimum essential coverage for a month during the plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period. *Id.* at (c)(3)(iii). The employer-sponsored plan year is the plan’s regular 12-month coverage period. *Id.* at (c)(3)(ii). Minnesota has adopted these same affordability and minimum value criteria with regard to MinnesotaCare coverage effective January 1, 2014. *Minn. Stat. § 256L.07, subd. 2 as amended in the Minnesota Session Laws, Chapter 108, Article 1, Section 55.*<sup>5</sup>

19. An eligible employer-sponsored plan is affordable for an employee or a related individual if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage of the applicable taxpayer's household income for the taxable year. 26 C.F.R. § 1.36B-2(c)(3)(v)(A)(1). The required contribution percentage is currently defined in paragraph (c)(3)(v)(C) of this section as 9.5 percent.

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<sup>5</sup> While the amendment to Minn. Stat. § 256L.07, subd. 2 is effective January 1, 2014 or upon federal approval, the Department of Human Services has extended the MinnesotaCare program and implemented the modifications of the program effective January 1, 2014 in anticipation of federal approval of this basic health plan under the Affordable Care Act retroactive to January 1, 2014.

20. An eligible employer-sponsored plan provides minimum value only if the plan's share of the total allowed costs of benefits provided to the employee under the plan is at least 60 percent. *26 C.F.R. § 1.36B-2I(3)(vi)*. Pursuant to 45 C.F.R. § 156.145 there are 3 ways to determine minimum value:

- Employer-sponsored plans may determine minimum value by entering information about cost-sharing features (deductibles, co-insurance and maximum out-of-pocket costs but not premium costs) of the plan for different categories of benefits into either the MV calculator.
- Safe harbor checklists may be used to determine minimum value for plans that cover all of the four core categories of benefits (1. Physician and mid-level practitioner care, 2. Hospital and emergency room services, 3. Pharmacy benefits, and 4. Laboratory and imaging services) and services and have specified cost-sharing amounts. If an employer-sponsored plan's terms are consistent with or more generous than any one of the safe harbor checklists the plan has minimum value.
- For employer-sponsored plans with "nonstandard" features such as quantitative limits on any of the four core categories of benefits (i.e. limits on the # of physician visits or covered hospital days) such plans may first generate an initial value using either the MV calculator and then engage a certified actuary to make appropriate adjustments to consider nonstandard features or simply engage the certified actuary to determine MV without the calculator.
- Any plan in the small group market that meets any of the levels of coverage set forth in 45 C.F.R. 156.140 satisfies minimum value.

21. 42 C.F.R. § 440.350(a) authorizes States to provide benchmark or benchmark-equivalent coverage by obtaining employer-sponsored health plans (either alone or with additional services covered separately under Medicaid) for individuals with access to private health insurance. Payment of premiums by the State, net of beneficiary contributions, to obtain benchmark or benchmark-equivalent benefit coverage on behalf of beneficiaries is treated as Medical Assistance. *42 C.F.R. § 440.355*. Pursuant to Minn. R. 9505.0430, the Medical Assistance program shall pay the cost of a premium to purchase health insurance coverage for a recipient when the premium purchases coverage limited to health services and the department approves the health insurance coverage as cost effective. "Cost-effective" is defined in Minn. Stat. § 256B.02, subd. 15 as when the amount paid by the state for premiums, coinsurance, deductibles, other cost-sharing obligations under a health insurance plan, and other administrative costs is likely to be less than the amount paid for an equivalent set of services paid by Medical Assistance.

## CONCLUSIONS OF LAW

22. This appeal is timely in that it was filed within 90 days of receipt of the Agency's determination that the Appellant is ineligible for advanced payment of a premium tax credit (APTC).

23. The Appellant seeks APTC assistance for health care insurance for himself only because his wife is enrolled in employer-sponsored coverage and his daughter is eligible for Medical Assistance benefits. It is uncontroverted that the Appellant is eligible for enrollment in a QHP, is expected to have MAGI within the applicable limits, and plans on claiming a personal exemption deduction. However, the Agency contends that the Appellant is eligible for enrollment in his wife's employer-sponsored health care coverage which provides minimum essential coverage.

24. [REDACTED] [REDACTED] is enrolled in employer-sponsored health insurance coverage. The Appellant was eligible for enrollment in this health insurance coverage during the open enrollment period in December 2013. However, the Appellant did not enroll in his wife's insurance coverage because of the additional cost of "single + 1" or "family" coverage. The Appellant does not contend that his wife's employer-sponsored coverage does not provide minimum value. It is noted that this plan's share of the total allowed costs of benefits provided to the employee under the plan is at least 60 percent.

25. With regard to the affordability of the employer-sponsored insurance which is available to the Appellant, the household's income for the benefit year is less than what was inputted into the MNsure application because the computerized process did not permit the input of the negative income reflected by a farm loss. The household's income as reported on their 2012 federal income tax return was \$26,267.00 as a result of a farm loss of -\$25,558.00. Such business losses are allowed as deductions in computing adjusted gross income for tax purposes. Furthermore, the Agency incorrectly included the income of [REDACTED] in computing the Appellant's eligibility for APTC. [REDACTED] is an unmarried individual who is not a surviving spouse or the head of household. Her income does not exceed \$22,100. Therefore, she is not required to file a tax return and her income should be excluded pursuant to 26 C.F.R. § 1.36B-1(e)(1).

26. Assuming that the Appellant will experience a similar farm loss for the applicable tax year, the cost of self-only employer-sponsored income must exceed \$2,495.00 annually to be unaffordable. Inasmuch as the Appellant's wife pays less than this amount annually for self-only coverage, her employer-sponsored insurance is affordable even considering the farm loss reported on the household's 2012 tax return. Affordability is determined by the cost of self-only coverage. Therefore, even if the cost of "single + 1" or "family" coverage exceeds 9.5 percent of the household income, [REDACTED]

health care coverage is affordable under the law. Accordingly, the Appellant is ineligible for advanced payment of a premium tax credit and MinnesotaCare coverage.

27. Eligibility for enrollment in employer-sponsored coverage is not a bar to the receipt of Medical Assistance benefits. The Appellant was unable to attest on his application to anticipated MAGI which included a business loss. Therefore, the Department of Human Services should redetermine the Appellant's eligibility for Medical Assistance based upon a correct projection of the household's 2014 anticipated adjusted gross income and if eligible provide such coverage to the Appellant retroactive to January 1, 2014 with written notice to the Appellant of its redetermination results. In the event the Appellant disagrees with the new determination, the Appellant may file a new appeal contesting the Medical Assistance determination.

28. The Agency's denial of the Appellant's application for advanced payment of a premium tax credit and MinnesotaCare coverage is upheld. The denial of Medical Assistance benefits is remanded.

29. This decision is effective January 1, 2014.

#### RECOMMENDED ORDER

#### THE APPEALS EXAMINER RECOMMENDS THAT:

The MNsure Board AFFIRM the Agency's determination to deny the Appellant's application for advance payment of a premium tax credit provided in the Affordable Care Act.

The Commissioner of the Minnesota Department of Human Services AFFIRM the determination that Appellant is not eligibility for MinnesotaCare coverage.

The Commissioner of the Minnesota Department of Human Services REMAND the determination that Appellant is not eligibility for Medical Assistance benefits and ORDER the Department of Human Services to redetermine the Appellant's eligibility for Medical Assistance based upon a correct projection of the household's 2014 anticipated adjusted gross income, to notify the Appellant in writing of its redetermination and if eligible to provide such coverage to the Appellant retroactive to January 1, 2014.

/s/ Douglass C. Alvarado  
Douglass C. Alvarado  
Appeals Examiner

February 14, 2014  
Date

ORDER

IT IS THEREFORE ORDERED THAT based upon all the evidence and proceedings, the MNSure Board and the Commissioner of the Minnesota Department of Human Services adopt the Appeals Examiner's findings of fact, conclusions of law and order as each agency's final decision.

FOR THE COMMISSIONER OF HUMAN SERVICES as to any effect the decision has on Appellant's eligibility for Medical Assistance and/or MinnesotaCare benefits.

FOR THE MNSURE BOARD as to any effect the decision has on Appellant's eligibility through MNSure for Advance Premium Tax Credits, Cost Sharing Reductions, Qualified Health Plan, and/or the Small Business Health Insurance Options Program.

\_\_\_\_\_  
Date

cc: [REDACTED] Appellant  
[REDACTED] MNSure  
[REDACTED] Minnesota Department of Human Services - 0989

**FURTHER APPEAL RIGHTS**

**This decision is final, unless you take further action.**

Appellants who disagree with this decision should consider seeking legal counsel to identify further legal recourse.

If you disagree with the effect this decision has on your eligibility for **Advance Premium Tax Credits, Cost Sharing Reductions, Qualified Health Plan, and/or the Small Business Health Insurance Options Program**, you may:

- **Appeal to the United States Department of Health and Human Services (DHHS)** under 42 U.S.C. § 18081(f) and 45 C.F.R. § 155.520(c). This decision is the final decision of MNSure, unless an appeal is made to DHHS. An appeal request may be made to DHHS *within 30 days of the date of this decision* by calling the Marketplace Call Center at 1-800-318-2596 (TTY 855-889-4325); or by downloading the appeals form for Minnesota from the appeals landing page on [www.healthcare.gov](http://www.healthcare.gov).

- **Seek judicial review to the extent it is available by law.**

If you disagree with this effect this decision has on your eligibility for **Medical Assistance and/or MinnesotaCare** benefits, you may:

- **Request the Appeals Office reconsider this decision.** The request must state the reasons why you believe your appeal should be reconsidered. The request may include legal arguments and may include proposed additional evidence supporting the request; however, if you submit additional evidence, you must explain why it was not provided at the time of the hearing. The request must be *in writing*, be made *within 30 days of the date of this decision*, and a *copy of the request must be sent to the other parties*. Send your written request, with your docket number listed, to:

Appeals Office  
Minnesota Department of Human Services  
P.O. Box 64941  
St. Paul, MN 55164-0941  
Fax: (651) 431-7523

- **Start an appeal in the district court.** This is a separate legal proceeding, and you must start this *within 30 days of the date of this decision* by serving a notice of appeal upon the other parties and the Commissioner. The law that describes this process is Minnesota Statute § 256.045, subdivision 7.