



**DECISION  
OF AGENCY  
ON APPEAL**

In the Appeal of: [REDACTED]

For: Medical Assistance  
MinnesotaCare  
Advance Payment of Premium Tax Credit  
Cost Sharing Reductions  
Qualified Health Plan

Agency: Minnesota Department of Human Services  
MNsure Board

Docket: 154754

On September 3, 2014; September 25, 2014 and October 13, 2014, Appeals Examiner Tonja J. Rolfson held an evidentiary hearing under 42 United States Code §18081(f), Minnesota Statute §62V.05, subdivision 6(a), and Minnesota Statute §256.045, subdivision 3.

The following people appeared at the hearing:

[REDACTED], Appellant; and  
Jessica Kennedy, MNsure Appeals Manager.

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 ISSUES

Whether the appellant is eligible for continuing benefits pending the appeal.

Whether the Minnesota Department of Human Services properly determined the household was not eligible for Medical Assistance and MinnesotaCare.

Whether the MNsure Board (“MNsure Agency”) properly determined the appellant’s eligibility for an advance payment of a premium tax credit and cost sharing reductions as provided in the Affordable Care Act.

Whether the appellant qualifies for a special enrollment period.

Whether the appellant qualifies for relief under the doctrine of equitable estoppel.

## FINDINGS OF FACT

1. The appellant filed an appeal on July 22, 2014. *Exhibit 1*. The Appeals Examiner scheduled a telephone hearing for August 21, 2014. The Appeals Examiner rescheduled it to September 3, 2013 by agreement of the parties. The Appeals Examiner held telephone hearings September 3, 2014, September 25, 2014 and October 13, 2014. The hearing was continued for the appellant’s benefit to allow the parties time to obtain necessary evidence and to permit negotiations of resolution between the parties. The Appeals Examiner closed the record on October 13, 2014. The Appeals Examiner reopened the record on October 27, 2014 to receive evidence regarding the benchmark plan at the time of the appellant’s application. The Appeals Examiner received the evidence on October 31, 2014 and marked it as Exhibit 7. The Appeals Examiner took official notice of Chart B of IRS Tax Form 1040 Instructions (2013) and included it in evidence as Exhibit 8. The Appeals Examiner accepted eight exhibits<sup>1</sup> into evidence and closed the record on October 31, 2014. The appellant’s benefits continued pending the appeal at the appellant’s request. *Testimony of the appellant*.

2. The appellant (age 50) applied for healthcare on October 6, 2013. *Exhibit 2, Attachment 1*. Her application included her spouse (age 61) and her two daughters (ages 23 and 20). *Id. at Attachment 2*. The appellant and her spouse file taxes jointly and claim her daughters as tax dependents. *Id. at Attachment 3*. Her husband already has health care benefits through the Veteran’s Administration. *Testimony of the appellant*. The appellant wanted to buy insurance for her and her daughters. *Id.* The parties do not dispute that the appellant and her daughters do not have insurance coverage available to them through work or elsewhere. The consumer portal of the MNsure website showed the appellant that her family was eligible for an advance premium

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<sup>1</sup> The exhibits are as follows: 1) Appeal Request; 2) State Agency Appeals Summary from William Welk, MinnesotaCare Representative; 3) State Agency Appeals Summary, Jessica Kennedy, MNsure Appeals Manager; 4) September 9, 2013 E-Mail from Jessica Kennedy; 5) September 18, 2014 E-mail from [REDACTED]; 6) September 22, 2014 E-mail from [REDACTED]; 7) Screen Print Showing the Premium was \$488.91 for the Benchmark Plan; and 8) Chart B of IRS Tax Form 1040 Instructions (2013).

tax credit of \$282.16 per month. *Exhibit 4*. When the appellant shopped for insurance through the portal, the portal showed that a gold plan with Preferred One was available for her and her daughters for \$280.50 per month. She signed up for that plan. After applying the advance premium tax credit of \$282.16, the website said the appellant's monthly premium for health coverage would be \$.34. *Exhibit 3*.

3. The appellant did not receive any written confirmation of her eligibility determination or insurance selection. The MNsure system is not able to send official eligibility determinations. Consumers receive their determination by speaking with the MNsure contact center, viewing the consumer portal and from insurance premium invoices. *Exhibit 3*.

4. In actuality, the MNsure website's consumer portal had shown the appellant eligibility results and premium offers for her as a household of one, not for insurance coverage for her and her daughters. *Exhibit 3*. According to MNsure, the "case worker portal," which the MNsure staff members view, contained the actual eligibility results. MNsure claims the household was only eligible for \$0 in advance premium tax credits. *Id.* However, this information was not communicated immediately to Preferred One. In January 2014 or February 2014, the appellant received a billing from Preferred One for a monthly premium of \$299.28. *Exhibit 3; Exhibit 4*. The total actual cost of the Preferred One gold plan for the appellant and her daughters was \$581.44. *Exhibit 4*. After applying the advance premium tax credit of \$282.16, the premium cost was \$299.28. *Id.* The appellant contacted MNsure on February 4, 2014. *Exhibit 3*. MNsure told the appellant her daughters had not been included in the initial calculation. *Id.* MNsure told her the \$299.28 premium amount was the correct premium amount for the family. *Exhibit 4*. The appellant told MNsure she could not afford this amount. *Exhibit 3*. Because open enrollment was still going on, MNsure told the appellant she could sign up for a different health plan. *Exhibit 3; Exhibit 4*. The appellant looked on the MNsure website, but could not find a plan that was within the family's budget that provided the same level of coverage she had. She decided to stay with the gold plan she had with Preferred One with a premium of \$299.28 per month. *Testimony of the appellant*.

5. After not hearing back from the appellant, on May 7, 2014, MNsure sent Preferred One the information that the appellant's correct advance premium tax credit was actually \$0. *Exhibit 4*. MNsure signed the appellant and the children up for the same Preferred One gold plan they were on retroactive to January 1, 2014. *Exhibit 4*. In July 2014, the appellant received a bill from Preferred One for the amounts since January 2014 that were now not covered by advance premium tax credits. This was the first the appellant learned she was not eligible for any advance premium tax credits. *Testimony of the appellant*. This appeal resulted.

6. MNsure argued the appellant was not entitled to continued benefits pending the appeal because this was an initial determination, not a redetermination. *Exhibit 3*. However, the appellant received benefits pending the appeal. She continued to pay the premium of \$299.29 for the Preferred One gold plan for her and the children while the appeal was pending. *Testimony of the appellant*.

7. MNSure worked with Preferred One during the appeal to come up with a resolution. Preferred One is willing to offer the appellant a bronze level plan at a monthly premium amount that is higher than what she is paying now and back date that plan to January 1, 2014. *Testimony of Jessica Kennedy*. The appellant is dissatisfied with that option because of the cost of the premium and because the deductible for that plan is over \$12,000 per year. *Testimony of the appellant*.

8. MNSure determined the appellant was eligible for 0% in cost sharing reductions. *Exhibit 2, Attachment 6*. This means MNSure determined the appellant is not eligible for reduced co-pays or deductibles.

9. The appellant did not dispute that her projected annual income was \$13,000, her spouse's was \$41,600, her 23 year-old daughter's was \$10,800 and her 20 year-old daughter's was \$3,900. *See Exhibit 2, Attachment 5*.

10. At the time of the application, the adjusted monthly premium of the benchmark plan was \$488.91 per month. *Exhibit 7*.

11. The appellant argues she should not have to pay for something she never agreed to buy. She wants continued coverage under the Preferred One gold level plan for \$299.28. The appellant's family has received covered health services under the Preferred One gold level plan. *Testimony of the appellant*.

## CONCLUSIONS OF LAW

### Timeliness and Jurisdiction

1. MNSure is required to provide timely written notice to an applicant of any eligibility determination it makes in the eligibility determination process. *45 C.F.R. § 155.310(g)*. MNSure did not provide written notices of its eligibility determinations as required by federal regulations. Because the appellant received no written notices regarding her eligibility from MNSure as required by federal regulation, the time for appeal did not begin to toll. Therefore, this appeal was started within the allowed time limits under Minnesota Statute § 256.045, subdivision 3(h) and 45 C.F.R §155.520(b).

2. The Commissioner of the Minnesota Department of Human Services has authority to review the appellant's household's eligibility for Medical Assistance and MinnesotaCare under Minnesota Statute § 256.045, subdivision 3, and the MNSure Board has legal authority to review Appellant's household's eligibility for premium assistance and cost sharing under Minnesota Statute § 62V.05, subdivision 6.

## Benefits Pending Appeal

3. Under 45 C.F.R. § 155.525(a), MNsure or the Minnesota Department of Human Services, as applicable, must continue to consider the appellant eligible while an appeal is pending when the appeal concerns a redetermination under §155.330(e) or an annual review under §155.335(h). If the appellant receives benefits pending the appeal and loses the appeal, the appellant is subject to reconciliation and repayment of any overpayment. *Minn. R. 7700.0105, subpart 15, item C.*

4. The evidence shows the appellant experienced what felt like no less than three different eligibility determinations. The first happened when she applied online for insurance in October 2013 and was informed by the website she was eligible for advance premium tax credits of \$282.16 and would pay \$.34 per month in premiums for a Preferred One gold plan for her and her daughters. The second was when she received a premium notice from Preferred One for \$299.28 per month and was told by MNsure that this was correct because her daughters had not been included in the initial calculation. The appellant paid premiums of \$299.28 per month to Preferred One. The third was when she received a bill from Preferred One for past due premiums caused by MNsure alerting Preferred One (unbeknownst to the appellant) that the family was actually ineligible for advance premium tax credits. However, under the law, “redeterminations” are triggered by updated or new information from or about the recipient or by an annual review. *45 C.F.R. § 155.330(e); 45 C.F.R. § 155.335(h).* There was no updated or new information here. The difficulty in the appellant’s case occurred not because of updated or new information, but because of miscommunications by MNsure to the parties about the appellant’s eligibility for advance premium tax credits based on the information the appellant provided at the time of open enrollment. Therefore, the appellant was not technically eligible for benefits pending the appeal. However, Preferred One continued the appellant’s benefits anyway at the appellant’s request.

## Modified Adjusted Gross Income (MAGI)

5. “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 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).*

6. “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<sup>2</sup> and are required to file a tax return for the taxable year. *26 C.F.R. §1.36B-1(e)(1).*

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<sup>2</sup> A “taxpayer's family” means the individuals for whom a taxpayer properly claims a deduction under 26 U.S.C. §151 for the taxable year. *26 C.F.R. §1.36B-1(d).* Family size means the number of individuals in the family. *Id.* Family and family size may include individuals who are not subject to or are exempt from the penalty under 26 U.S.C. § 5000A for failing to maintain minimum essential coverage. *Id.*

7. Generally, household income is the sum of the MAGI-based income of every individual included in the individual's household. *42 C.F.R. § 435.603(d); Minnesota Department of Human Services Insurance Affordability Programs Manual, Chapter 300.10.10.10*. The MAGI-based income of an individual who is included in the household of his or her natural, adopted or stepparent and is not expected to be required to file a tax return under section 6012(a)(1) of the Internal Revenue Code for the taxable year in which eligibility for Medical Assistance is being determined, is not included in household income whether or not the individual files a tax return. *42 C.F.R. § 435.603(d)(2); Minnesota Department of Human Services Insurance Affordability Programs Manual (IAPM), Chapter 300.10.10.10*.

8. Because the appellant's 20 year-old daughter's was earning less than \$6100, she would not be required to file a tax return. *See Exhibit 8 (Chart B of IRS Tax Form 1040 Instructions (2013))*.

9. Because the income of the appellant's 20 year-old daughter is excluded, the household's MAGI income is therefore, \$65,400 (i.e., \$13,000 + \$41,600 + \$10,800 = \$65,400). The appellant's household income is 277% of the 2013 federal poverty level, which is \$23,550 for a household size of four persons [ $\$65,400 \div \$23,550 = 2.777 \times 100 = 278\%$  rounded].<sup>3</sup>

#### Medical Assistance

10. 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 Medical Assistance.<sup>4</sup>

11. The state laws about Medical Assistance are in Minnesota Statutes, Chapter 256B. Effective January 1, 2014, to be eligible for Medical Assistance, a parent or caretaker relative, an adult without children, and a child age 19 to 20 may have an income up to 133% of the federal poverty guidelines for the household size. *Minn. Stat. § 256B.056, subd. 4(b), (c), and (d)*. Effective January 1, 2014, to be eligible for Medical Assistance, a child under age 19 may have income up to 275% of the federal poverty guidelines for the household size. *Id. at subd. 4(e)*.

12. The MAGI methodology as defined in the Affordable Care Act is used for determining income in these eligibility categories except that the Commissioner must subtract from the MAGI an amount equivalent to five percent of the federal poverty guidelines. *Minn. Stat. § 256B.056, subd. 1a(b)(1) and (2); See also 42 C.F.R. § 435.603(c)(4)*. Therefore, for the purposes of determining Medical Assistance eligibility, the household's income is 273% of the federal poverty guidelines (i.e.,  $278\% - 5\% = 273\%$ ). Because household income exceeds 133% and neither daughter is under the age of 20, no one in the household qualifies for Medical Assistance.

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<sup>3</sup> *Federal Register, Vol. 78, No. 16, January 24, 2013, p. 5183.*

<sup>4</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)).

## MinnesotaCare

13. The state laws about MinnesotaCare are in Minnesota Statutes, Chapter 256L. Effective January 1, 2014,<sup>5</sup> single adults, families with no children and families with children with family income above 133 percent and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size are eligible for MinnesotaCare. *Minn. Stat. § 256L.04, subd. 1 and subd. 7.* Children under age 19 with family income at or below 200 percent of the federal poverty guidelines and who are ineligible for Medical Assistance by sole reason of the application of federal household composition rules for Medical Assistance are eligible for MinnesotaCare. *Minn. Stat. § 256L.04, subd. 1.*

14. Effective January 1, 2014, for MinnesotaCare eligibility “income” has the meaning given for modified adjusted gross income (MAGI) as defined in Code of Federal Regulations, title 26, section 1.36B-1.6 *Minn. Stat. § 256L.01, subd. 5.*

15. Effective January 1, 2014, for MinnesotaCare eligibility “family” has the meaning given for family and family size as defined in Code of Federal Regulations, title 26, section 1.36B-1.7 *Minn. Stat. § 256L.01, subd. 3a(a).*

16. Because the appellant’s family income is above 200% of the federal poverty level, the Department of Human Services correctly determined the appellant and her daughters were not eligible for MinnesotaCare.

## Premium Assistance

17. Federal regulations concerning eligibility for advance payment of a premium tax credit 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 an advance premium tax credit if he or she is expected to have household income, as defined in 26 C.F.R. 1.36B-1(e), 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 for whom the tax filer expects to claim a personal exemption deduction on his or her federal tax return for the benefit year are: (a) eligible for enrollment in a Qualified Health Plan through the Exchange as specified in 45 C.F.R. 155.305(a), and (b) are not eligible for minimum essential coverage, with the exception of coverage in the individual market, in accordance with section 26 C.F.R. 1.36B-(a)(2) and (c). *45 C.F.R. §155.305(f).*

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<sup>5</sup> *Laws 2013, chapter 108, article 1, section 42.* The Department of Human Services received federal approval of the changes made to the MinnesotaCare program on December 20, 2013. See [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_177299](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_177299).

<sup>6</sup> *Laws 2013, chapter 108, article 1, section 30.*

<sup>7</sup> *Laws 2013, chapter 108, article 1, section 29.*

18. Appellant meets the general requirements to be eligible for premium assistance or advance payment of the premium tax credit as provided in 45 C.F.R. §155.305(f) because:

- (a) Appellant is expected to have a household income, as defined in 26 C.F.R. §1.36B-1(e), of greater than or equal to 100% but not more than 400% of the federal poverty level of benefit year for which coverage is requested;
- (b) Appellant is eligible to enroll in a Qualified Health Plan through MNsure as specified in 45 C.F.R. §155.305(a); and
- (c) Appellant is not already eligible for minimum essential coverage, with the exception of coverage in the individual market, in accordance with 26 C.F.R. §1.36B-(a)(2) and (c).

19. A taxpayer's premium assistance credit amount for a taxable year is the sum of the premium assistance amounts determined under 26 C.F.R. §1.36B-3(d) for all coverage months for individuals in the taxpayer's family. *26 C.F.R. §1.36B-3(a).*

20. The premium assistance amount for a coverage month is the lesser of: (1) the premiums for the month for one or more qualified health plans in which a taxpayer or a member of the taxpayer's family enrolls through the Exchange; or (2) the excess of the adjusted monthly premium for the applicable benchmark plan (second lowest-cost silver plan) over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year. *26 C.F.R. §1.36B-3(d).*

21. The adjusted monthly premium is the premium an insurer would charge for the applicable benchmark plan to cover all members of the taxpayer's coverage family, adjusted only for the age of each member of the coverage family as allowed under section 2701 of the Public Health Service Act (42 U.S.C. 300GG). *26 C.F.R. §1.36B-3(e).* The adjusted monthly premium is determined without regard to any premium discount or rebate under the wellness discount demonstration project under 2705(d) of the Public Health Service Act, and may not include any adjustments for tobacco use. *Id.*

22. The applicable benchmark plan for each coverage month is the second lowest-cost silver plan as described in section 1302(d)(1)(B) of the Affordable Care Act offered through the Exchange for the rating area where the taxpayer resides. *26 C.F.R. §1.36B-3(f).* The applicable benchmark plan provides self-only or family coverage. *Id.* Self-only coverage is for a taxpayer: (1) who computes tax under 26 U.S.C. §1(c) (meaning unmarried individuals other than surviving spouses and heads of household) and is not allowed a deduction under section 151 for a dependent for the taxable year; (2) who purchases only self-only coverage for one individual; or (3) whose coverage family includes only one individual. *26 C.F.R. §1.36B-3(f)(1)(i).* Family coverage is for all other taxpayers. *26 C.F.R. §1.36B-3(f)(1)(ii).* The applicable benchmark plan for family coverage is the second lowest cost silver plan that applies to the members of the taxpayer's coverage family (such as a plan covering two adults if the members of a taxpayer's coverage family are two adults). *26 C.F.R. §1.36B-3(f)(2).*

23. There are several steps to calculate the applicable percentage. First, the percentage that the taxpayer's household income bears to the federal poverty line for the taxpayer's family size needs to be determined. Second, the resulting federal poverty line percentage is compared to the income categories described in the table in 26 C.F.R. §1.36B-3(g)(2). Third, an applicable percentage within an income category increases on a sliding scale in a linear manner, and is rounded to the nearest one-hundredth of one percent. 26 C.F.R. §1.36B-3(g)(2).

24. The applicable percentage table is:

<b>Household income percentage of federal poverty line</b>	<b>Initial percentage</b>	<b>Final percentage</b>
Less than 133%	2	2
At least 133% but less than 150%	3	4
At least 150% but less than 200%	4	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At last 300% but less than 400%	9.5	9.5

26 C.F.R. §1.36B-3(g)(2).

25. The appellant's applicable percentage is 8.67. This determination is made as follows. The initial percentage for a taxpayer with household income at least 250% but less than 300% of the federal poverty line is 8.05 and the final percentage is 9.5. The excess of the appellant's federal poverty line percentage (273) over the initial household income percentage in the appellant's range (250) is 23. The difference between the initial household income percentage in the taxpayer's range and the final household income percentage in the taxpayer's range is 50 (i.e.,  $300 - 250 = 50$ ). The result of dividing the first calculation by the second calculation is .43 (i.e.,  $23/50 = .43$ ). The difference between the initial premium percentage and the final household income percentage in the taxpayer's range is 1.45 (i.e.,  $9.5 - 8.05 = 1.45$ ). The product of multiplying this difference (1.45) by the result of dividing the first and second calculation (.43) is .6235. Adding this product (.6235) to the initial premium percentage in the taxpayer's range (8.05) results in the appellant's applicable percentage of 8.67.

26. The appellant's required contribution toward premiums at the time of application was \$472.52 per month. This is calculated by multiplying 8.67% by the household's MAGI of \$65,400 and dividing that number by 12 months (i.e.,  $\$65,400 \times .0867 = \$5670.18 / 12 = \$472.515$  or \$472.52). Subtracting this from the benchmark plan premium of \$488.91 means the family was eligible either for \$16.39 per month in advance premium tax credits (or the amount of the premium for a plan on the exchange selected by the appellant if that premium amount was less than \$16.39 per month).

## Cost-Sharing Reductions

27. Federal regulations concerning eligibility for cost-sharing reductions (CSR) are found at 45 C.F.R. §155.305(g). The MNsure agency must determine an applicant eligible for cost-sharing reductions if the applicant meets the following eligibility requirements:

- (A) The applicant meets the requirements for eligibility for enrollment in a Qualified Health Plan through the Exchange;
- (B) The applicant meets the requirements for advance payments of the premium tax credit; and
- (C) The applicant is expected to have a household income that does not exceed 250 percent of the Federal Poverty Level, for the benefit year for which coverage is requested.

*45 C.F.R. §155.305(g)(1)(i).* MNsure may only provide cost-sharing reductions to an enrollee who is not an Indian if he or she is enrolled through the Exchange in a silver-level Qualified Health Plan, as defined by section 1302(d)(1)(B) of the Affordable Care Act. *45 C.F.R. §155.305(g)(1)(ii).*

28. Because the appellant's household income exceeds 250% of the federal poverty level, the household was not eligible for cost-sharing reductions.

## Special Enrollment Period

29. Federal regulations concerning enrollment in qualified health plans (QHPs) are found at 45 C.F.R. §§155.400 – 155.430. The Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the initial open enrollment period, the annual open enrollment period, or a special enrollment period described in 45 C.F.R. §155.420 for which the qualified individual has been determined eligible. *45 C.F.R. §155.400(a)(2).* The initial open enrollment period began October 1, 2013 and extended through March 31, 2014. *45 C.F.R. §155.400(b).* For the benefit year beginning on January 1, 2015, the annual open enrollment period begins on November 15, 2014, and extends through February 15, 2015. *45 C.F.R. §155.400(e).*

30. The Exchange must allow a qualified individual or enrollee, and, when specified, his or her dependent, to enroll in or change from one QHP to another via a special enrollment period if one of the following triggering events occur:...

4) The qualified individual's or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;....

9) The qualified individual or enrollee, or his or her dependent, demonstrates to the

Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

45 C.F.R. §155.420(d).

31. On March 26, 2014, the Department of Health & Human Services Centers for Medicare & Medicaid Services (CMS) released guidance for special enrollment periods available in complex cases where specific circumstances blocked a consumer from enrolling in coverage, even though they started the application process on or before March 31st.

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/in-line-SEP-3-26-2014.pdf> These special enrollment periods allow a consumer to enroll in health coverage outside of the open enrollment period. *Id.* The CMS created a chart representing categories of individuals that CMS determined eligible for special enrollment period under paragraphs (d)(4), (d)(9), and (d)(10) of 45 C.F.R. § 155.420, and further indicated that additional categories may be added in the future other appropriate circumstances, as determined by CMS, become known.

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf> The chart provides the following:

<b>Limited Circumstance Special Enrollment Periods</b>	<b>Description</b>	<b>Examples</b>
Exceptional Circumstances	A consumer faces exceptional circumstances as determined by CMS, such as a natural disaster, medical emergency, and planned system outages that occur on or around plan selection deadlines.	A natural disaster, such as an earthquake, massive flooding, or hurricane. <ul style="list-style-type: none"> <li>• A serious medical condition, such as an unexpected hospitalization or a temporary cognitive disability</li> <li>• A planned Marketplace system outage, such as SSA system outage</li> </ul>
Misinformation, Misrepresentation, or Inaction	Misconduct by individuals or entities providing formal enrollment assistance (like an insurance company, Navigator, certified application counselor, Call Center Representative, or agent or broker) resulted in one of the following: <ul style="list-style-type: none"> <li>• A failure to enroll the consumer in a plan</li> <li>• Consumers being enrolled in the wrong plan against their wish</li> </ul>	Representative enrolled a consumer in a plan that the consumer did not want to enroll in

	<ul style="list-style-type: none"> <li>• The consumer did not receive advanced premium tax credits or cost-sharing reductions for which they were eligible.</li> </ul>	
Enrollment Error	Consumers enrolled through the Marketplace, but the insurance company didn't get their information due to technical issues.	<p>Consumer's information is received by the insurance company and may be processed, but the enrollment file contains defective or missing data which makes the insurance company unable to enroll the consumer.</p> <ul style="list-style-type: none"> <li>• Consumer's application may have been rejected by the issuer's system because of errors in reading the data.</li> </ul>
System errors related to immigration status	An error in the processing of applications submitted by immigrants caused the consumer to get an incorrect eligibility result when they tried to apply for coverage.	Immigrants with income under 100% of the poverty line who are eligible for premium tax credits and cost-sharing reductions did not receive the proper determination.
Display Errors on Marketplace website	Incorrect plan data was displayed at the time the consumer selected the QHP, such as plan benefit and cost-sharing information.	<ul style="list-style-type: none"> <li>• Data errors on premiums, benefits, or co-pay/deductibles.</li> <li>• Errors that resulted in the display of a QHP to applicants that were outside of the QHP's service area or that were in ineligible enrollment groups.</li> <li>• Errors that didn't allow consumers with certain categories of family relationships to enroll together in a single plan with their family members.</li> </ul>
Medicaid/CHIP - Marketplace transfer	Consumers who were found ineligible for Medicaid or CHIP and their applications weren't transferred between the State Medicaid or CHIP agency and the Marketplace in time for the consumer to	<ul style="list-style-type: none"> <li>• Consumers, who applied at the FFM, were assessed eligible for Medicaid or CHIP, were found ineligible for Medicaid or CHIP by the state agency and then weren't transferred back in time for an</li> </ul>

	enroll in a plan during open enrollment.	FFM determination during open enrollment. <ul style="list-style-type: none"> <li>• Consumers who applied at the state Medicaid or CHIP agency during open enrollment and ended up having their cases referred to the Marketplace after a denial of Medicaid or CHIP.</li> </ul>
Error messages	A consumer is not able to complete enrollment due to error messages.	<ul style="list-style-type: none"> <li>• Error or box screen indicating that the data sources were down and they could not proceed with enrollment.</li> </ul>
Unresolved casework	A consumer is working with a caseworker on an enrollment issue that is not resolved prior to March 31st.	<ul style="list-style-type: none"> <li>• Consumers who began the case work process but it was not resolved prior to the end of open enrollment.</li> </ul>
Victims of domestic abuse	A consumer who is married, and is a victim of domestic abuse. Consumers who are in this category can apply and select a plan through May 31, 2014.	Prior to clarifying guidance from Treasury and HHS, consumer assumed or was informed that APTC were unavailable to consumers who are married and not filing a joint tax return. Consumer may or may not have attempted to apply.
Other system errors	Other system errors, as determined by CMS, which hindered enrollment completion.	

*Id.*

32. The appellant’s circumstances fit under a number of these enumerated special circumstances. At open enrollment, the appellant was given incorrect information regarding the amount of advance premium tax credits for which she was eligible. She signed up for a plan she otherwise would not have picked. She was again misinformed about her eligibility for advance premium tax credits in February 2014 and decided to stay with the Preferred One gold plan at a premium of \$299.28 per month because MNSure told her it was the correct premium for her and her daughters. She did not find out she was not eligible for advance premium tax credits until June 2014—after open enrollment had ended. Therefore, the appellant is eligible for a special enrollment period.

33. In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs 45 C.F.R. § 155.420(d)(4), (d)(5), (d)(9), or (d)(10), the Exchange must ensure the change is effective on an appropriate date based on the circumstances of the special enrollment period. 45 C.F.R. § 155.420(b)(2)(iii); 45 C.F.R. § 155.330(f)(5). The appellant applied and selected a qualified health plan before December 23, 2014. Had all gone properly, the appellant would have had an effective coverage date of January 1, 2014. See 45 C.F.R. § 155.410(c)(i). Therefore, January 1, 2014 is the appropriate effective date for the change in advance premium tax credits as well as for coverage under a new qualified health plan.

34. Based on this, Preferred One's offer to allow the appellant to switch to a bronze level plan effective January 1, 2014 is allowed by law. Technically, the appellant is eligible to switch to a qualified health plan offered by a managed care plan other than Preferred One. However, practically, the appellant has little choice if she wants to reduce her losses. The appellant received benefits in error from Preferred One as of January 1, 2014 at a gold plan level at a reduced price. She then received continued benefits pending the appeal from Preferred One to which she was not entitled. If she decides to switch to a qualified health plan with a different managed care plan, she would still owe Preferred One for benefits received—and then be required to pay premiums to the new managed health plan.

35. The appellant argues she should not have to pay for what she did not agree to buy. However, the facts show that what the appellant is receiving now (a gold plan at a reduced rate) is not what Preferred One agreed to sell, either. The confusion between buyer (the appellant) and seller (Preferred One) occurred because of miscommunication by MNSure regarding the appellant's eligibility for advance premium tax credits and QHP premiums. The doctrine of equitable estoppel may be raised when a party reasonably and detrimentally relied on the words or conduct of another. See *In the Matter of Westling Manufacturing*, 442 N.W.2d 328 (Minn. App. 1989). To establish a claim of equitable estoppel against a government agency, an appellant must prove three elements. First, she must show the agency made misrepresentations to her. Second, she must demonstrate she reasonably relied on these misrepresentations to her detriment. See *Department of Human Services v. Muriel Humphrey Residences*, 436 N.W.2d 110, 117 (Minn. App. 1989). Finally, the doctrine of equitable estoppel cannot be applied when the plain language of the law does not allow for such an equitable consideration. The evidence shows the agency made misrepresentations and the appellant relied on them to her detriment. However, when an individual seeks to estop a government agency "some element of fault or wrongful conduct must be shown." *Westling*, 442 N.W.2d at 332. Also, the wrongful conduct must be what is described as "affirmative misconduct." *Schweiker v. Hanson*, 459 U.S. 790 (1981). This requires more than mere negligence; to invoke estoppel the agency's misrepresentation must be willful or at least reckless. *Id.* The evidence shows that MNSure's actions were negligent but do not meet the threshold standard of willful or reckless.

RECOMMENDED ORDER

THE APPEALS EXAMINER RECOMMENDS THAT:

- The MNsure Board AFFIRM its determination that the appellant did not qualify for continued benefits pending the appeal;
- The Commissioner of the Minnesota Department of Human Services AFFIRM the determination that the appellant's household was not eligible for Medical Assistance as of January 1, 2014;
- The Commissioner of the Minnesota Department of Human Services AFFIRM the determination that the appellant's household was not eligible for MinnesotaCare benefits as of January 1, 2014;
- The MNsure Board REVERSE the determination that the appellant was eligible for an advance premium tax credit of zero as of January 1, 2014; and ORDER the MNsure Board to allow the appellant an advance premium tax credit of \$16.39 beginning January 1, 2014 AND to allow the appellant retroactive coverage under a qualified health plan of the appellant's choice going back to January 1, 2014 if the appellant elects retroactive coverage in those months by contacting Jessica Kennedy, MNsure Appeals Manager & Legal Counsel at [Jessica.M.Kennedy@state.mn.us](mailto:Jessica.M.Kennedy@state.mn.us) within two weeks of the date of this decision; and
- The MNsure Board AFFIRM the determination that the appellant was not eligible for cost-sharing reductions.

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Tonja J. Rolfson  
Appeals Examiner

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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  
Michael Turpin, MNsure  
Teresa Saybe, Minnesota Department of Human Services - 0838

## 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.