



**DECISION OF
MNSURE BOARD
ON APPEAL**

In the Appeal of: [REDACTED]
For: Qualified Health Plan (QHP)
Agency: MNSure Board
Docket: 155208

On September 4, 2014, Appeals Examiner Diane Gnotta held an evidentiary hearing under 42 United States Code §18081(f) and Minnesota Statute §62V.05, subdivision 6(a).

The following people appeared at the hearing:

[REDACTED], Appellant.

Based on the evidence in the record and considering the arguments of the parties, the appeals examiner recommends the following findings of fact, conclusions of law, and order.

STATEMENT OF ISSUE

Whether the MNsure Board properly determined the effective date of the Qualified Health Plan coverage for appellant's spouse pursuant to the Affordable Care Act.

FINDINGS OF FACT

1. The MNsure Board (herein MNsure) advised the appellant that his request to make his spouse's qualified health plan coverage effective May 1, 2014 rather than February 1, 2014, and reimbursement of \$1,077.48 for his spouse's backdated premium coverage to February 1, 2014 was denied. *Exhibits A and B; Testimony of the Appellant.* The appellant filed a request challenging these determinations, which MNsure received on August 6, 2014. An evidentiary hearing was initially scheduled for August 29, 2014, but was continued until September 4, 2014. On September 4, 2014, Appeals Examiner Gnotta held an evidentiary hearing via telephone conference. The appeals examiner accepted into evidence one exhibit from MNsure and two exhibits from the appellant. The record was closed at the conclusion of the hearing.

2. On December 13, 2013, the appellant submitted an online application through MNsure for health coverage for himself and his spouse, selected a Blue Cross Blue Shield health plan, and paid the premium amount of \$406.01 as instructed to MNsure. *Exhibits A, B, and 1; Testimony of Appellant.*

3. During January 2014, appellant received medical and dental insurance cards from Blue Cross Blue Shield only for himself, and not for his spouse. *Exhibit B; Testimony of Appellant.* Appellant spoke with a Blue Cross Blue Shield representative and learned that his spouse was not insured. *Id.*

4. On January 13, 2014, appellant spoke with a representative from MNsure, who confirmed that appellant's spouse had been dropped from the application due to system glitches, and appellant was advised that his spouse would be manually added to his coverage effective February 1, 2014 with a premium due of \$718.32 for coverage for both appellant and his spouse, which appellant remitted. *Exhibit B; Testimony of Appellant.*

5. During February 2014, appellant received a premium statement from Blue Cross Blue Shield indicating that it issued a credit to appellant's account for overpayment of premium. *Exhibit B; Testimony of Appellant.* Appellant spoke with representatives from both Blue Cross Blue Shield and MNsure, who confirmed that appellant's spouse still had not been added to his insurance coverage, but would be manually added to appellant's coverage. *Id.*

6. MNsure concedes it became aware on February 20, 2014 that there was a

further delay in adding coverage for appellant's spouse. *Exhibit 1.*

7. During March 2014, appellant contacted Blue Cross Blue Shield to verify that his spouse had been added to his coverage, and was informed that Blue Cross Blue Shield had not yet received a transmittal from MNsure to add his spouse to his coverage. *Exhibit B; Testimony of Appellant.*

8. During March 2014, MNsure contacted appellant to inform him that it had created a new account with Blue Cross Blue Shield, which was set up in his spouse's name, and listed appellant as his spouse's dependent. *Exhibit B; Testimony of Appellant.*

9. On March 17, 2014, appellant's spouse received a QHP selection confirmation letter from Blue Cross Blue Shield that her insurance coverage would start on May 1, 2014 based on premium payments of \$718.32 received after March 15, 2014. *Exhibit B; Testimony of Appellant.* Appellant's spouse received her insurance cards during May 2014. *Exhibit A.*

10. On May 5, 2014, appellant received a letter from Blue Cross Blue Shield indicating that his old insurance account had been terminated because he was now under his spouse's insurance account. *Exhibit B.*

11. Appellant accessed his auto-payment insurance account through Blue Cross and Blue Shield, and learned that \$1,077.48 in premiums had been debited because his spouse's coverage had been backdated to February 1, 2014 pursuant to MNsure's instructions to Blue Cross Blue Shield. *Exhibit B; Testimony of Appellant.*

12. Appellant's spouse did not incur any medical expenses prior to May 1, 2014. *Exhibit B.*

13. Appellant argues that he did not authorize MNsure to backdate his spouse's coverage to February 1, 2014 in light of the circumstances that delayed confirmation of his spouse's QHP selection until March 2014, and that \$1,077.48 should be refunded to appellant. *Exhibit B; Testimony of Appellant.*

14. MNsure argues that it correctly determined the effective date of coverage for appellant and his spouse based on their initial December 14, 2013 health plan selection attempt, and subsequent January 2014 notification by appellant of the enrollment problems of his spouse due to MNsure system glitches. *Exhibit 1.*

CONCLUSIONS OF LAW

1. Pursuant to 45 C.F.R. § 155.520(b)(1) and Minn. R. 7700.0105, subp. 2(D) an appeal regarding advance payment of a premium tax credit, cost-sharing reductions and qualified health plan issues must be received within 90 days from the date of the notice of eligibility determination. This appeal has been timely filed.

2. 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 (APTC), Cost Sharing Reductions (CSRs), Qualified Health Plan(QHP), 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.¹

3. In accordance with Minn. R. 7700.0105 MNsure appeals are available for the following actions:

(1) initial determinations and redeterminations made by MNsure of individual eligibility to purchase a qualified health plan through MNsure;

(2) initial determinations and redeterminations made by MNsure of eligibility for and level of advance payment of premium tax credit, and eligibility for and level of cost sharing reductions;

(3) initial determinations and redeterminations made by MNsure of employer eligibility to purchase coverage for qualified employees through the Small Business Health Options Program;

(4) initial determinations and redeterminations made by MNsure of employee eligibility to purchase coverage through the Small Business Health Options Program;

(5) initial determinations and redeterminations made by MNsure of individual eligibility for an exemption from the individual responsibility requirement;

(6) a failure by MNsure to provide timely notice of an eligibility determination;

(7) a determination by MNsure that an employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide coverage but is not affordable coverage with respect to an employee; and§

(8) a denial of a request to vacate a dismissal.

4. 45 C.F.R. 155.310(e) requires that Health Care Exchanges must make eligibility determinations promptly and without undue delay.

5. Pursuant to 45 C.F.R. 155.410(a)(2) 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 for which the qualified individual has been determined eligible. The initial open

¹ Id.

enrollment period begins October 1, 2013 and extends through March 31, 2014. *Id.* at (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. *Id.* at (e). 45 C.F.R. 155.420(d) sets forth the special enrollment period criteria. The Exchange must allow a qualified individual or enrollee to enroll in or change from one QHP to another if:

- 1) the qualified individual or his or her dependent loses minimum essential coverage;
- 2) the qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care;
- 3) the qualified individual, or his or her dependent, which was not previously a citizen, national, or lawfully present individual gains such status;
- 4) the qualified individual'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;
- 5) the enrollee or, his or her dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- 6) the enrollee is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;
- 7) the qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move;
- 8) the qualified individual is an Indian;
- 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; or
- 10) it has been determined by the Exchange that a qualified individual or enrollee, or his or her dependents, was not enrolled in QHP coverage; was not enrolled in the QHP selected by the qualified individual or enrollee; or is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

6. On March 26, 2014, the Department of Health & Human Services Centers for Medicare & Medicaid Services (CMS) released guidance for the Federally facilitated Marketplace concerning 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 and have it be effective for that coverage

year. *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> In relevant part, the chart provides the following:

| Limited Circumstance Special Enrollment Periods | Description | Examples |
|--|---|--|
| 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"> • Data errors on premiums, benefits, or co-pay/deductibles. • 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. • Errors that didn’t allow consumers with certain categories of family relationships to enroll together in a single plan with their family members. |
| Error messages | A consumer is not able to complete enrollment due to error messages. | <ul style="list-style-type: none"> • Error or box screen indicating that the data sources were down and they could not proceed with enrollment. |
| 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"> • Consumers who began the case work process but it was not resolved prior to the end of open enrollment. |

Id.

7. Pursuant to 45 C.F.R. 155.400(a), the Health Care Exchange must accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP, and must: (1) notify the issuer of the applicant's selected QHP; and (2) transmit information necessary to enable the QHP issuer to enroll the applicant. The Exchange must: (1) send eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay; (2) establish a process by which a QHP issuer acknowledges the receipt of such information; and (3) send updated eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS. *Id.* at (b). The Exchange must also maintain records of all enrollments in QHP issuers through the Exchange and reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis. *Id.* at (c) & (d).

8. For a QHP selection received by the Exchange from a qualified individual between the first and fifteenth day of any subsequent month during the initial open enrollment period, the Exchange must ensure a coverage effective date of the first day of the following month. 45 C.F.R. § 155.410(c)(1)(ii). For a QHP selection received by the Exchange between the sixteenth and last day of the month for any month between January 2014 and March 31, 2014 the Exchange must ensure a coverage effective date of the first day of the second following month. *Id.* at (c)(1)(iii). The federal rules do allow exchanges the option to provide an earlier effective date when agreed to by all participating QHP issuers. *Id.* at (c)(2)(ii).

9. After the release of the March 26, 2014 federally facilitated exchange guidance, MNsure released its own guidance concerning when an individual may enroll in a Qualified Health Plan or change Qualified Health Plan enrollment during a special enrollment period, which included the following circumstances: in situations in which a consumer's or dependent's enrollment, disenrollment, or lack of enrollment option in a QHP was the result of MNsure error, a special 60-day enrollment period would commence on the date the error was reported and coverage would begin on the date the coverage would have started absent the MNsure error. <https://www.mnsure.org/images/SEP-guide-v2.pdf>.

10. On April 29, 2014, MNsure released a Bulletin concerning implementation of retroactive coverage under exceptional circumstances, which included the following guidelines: consumers must have attempted to obtain coverage during the initial Open Enrollment period (October 1, 2013 through March 31, 2014) in order to be eligible for retroactive coverage; a consumer cannot have retroactive coverage earlier than January 1, 2014 or later than May 1, 2014, with the effective date based on when the consumer first attempted to enroll through MNsure; a consumer may choose whether or not to receive retroactive coverage; and a consumer who wishes to obtain retroactive coverage must inform MNsure of that election by May 15, 2014 by calling the MNsure Contact Center at 1.855.366.7873. <https://www.mnsure.org/images/retro-coverage-policy-2014-04-29.pdf>.

11. The appeals examiner finds that the effective date of enrollment for appellant's spouse is May 1, 2014 based on the following evidence: MNsure created a new insurance account for appellant's spouse during March 2014, while the initial open enrollment period was still in effect, in order to complete the spouse's enrollment in the selected QHP; MNsure had no record of QHP selection concerning appellant's spouse prior to the March 2014 timeframe; and the Blue Cross Blue Shield letter confirming the QHP selection of appellant's spouse was dated March 17, 2014. In the present case, the appellant is not contesting the determination regarding his spouse's eligibility to enroll in a QHP. Rather, appellant is contesting the retroactive coverage of his spouse's insurance, which was effected by MNsure without appellant's permission, and appellant is seeking reimbursement of the premiums paid for that retroactive coverage period. The evidence shows that appellant and his spouse first attempted to enroll in health insurance coverage through MNsure during December 2013, but only appellant's QHP selection was confirmed and processed by MNsure due to apparent MNsure system problems. The evidence shows that despite appellant's report to MNsure during January 2014 that his spouse had been dropped from the QHP selection process, the QHP selection for appellant's spouse was not corrected until March 2014, at which time MNsure decided to correct the problem by creating a new insurance account under the name of appellant's spouse and listing appellant as his spouse's dependent. The evidence shows that on March 17, 2014, Blue Cross Blue Shield issued an enrollment confirmation to appellant's spouse indicating an effective date of coverage of May 1, 2014 if \$718.32 in premium payments were received by March 31, 2014. The evidence further shows that on May 5, 2014, appellant received a letter from Blue Cross Blue Shield indicating that appellant's former insurance account would be terminated because he was now listed under his spouse's coverage. MNsure has not presented any evidence that the retroactive coverage of appellant's spouse to February 1, 2014 was expressly requested by either appellant or his spouse, and MNsure's decision to apply retroactive coverage for appellant's spouse without express permission from appellant or his spouse appears to be inconsistent with MNsure's own policy concerning implementation of retroactive coverage, which states that retroactive coverage is at the election of the consumer. Although the scope of subject matter jurisdiction governing MNsure appeals does not include the reimbursement of paid premiums in situations that arise from a dispute concerning effective date of coverage, the appeals examiner notes that appellant may have recourse through the Blue Cross Blue Shield internal grievance and health plan appeal process to resolve that matter. The appeals examiner reverses the MNsure action of retroactive coverage of appellant's spouse to February 1, 2014, absent evidence of such an election by appellant or his spouse, and finds that the effective date of coverage for appellant's spouse is May 1, 2014.

RECOMMENDED ORDER

THE APPEALS EXAMINER RECOMMENDS THAT MNsure's decision to apply retroactive coverage for appellant's spouse be REVERSED with instructions to MNsure to transmit to Blue Cross and Blue Shield a corrected effective date of coverage

for appellant's spouse of May 1, 2014.

Diane Gnotta
Appeals Examiner

Date

ORDER OF THE MNSURE BOARD

IT IS THEREFORE ORDERED THAT based upon all the evidence and proceedings, the MNSure Board adopts the Appeals Examiner's recommendation as the final decision.

FOR THE MNSure Board:

Date

cc: [REDACTED], Appellant
Michael Turpin, MNSure

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