



**DECISION
OF AGENCY
ON APPEAL**

In the Appeal of: [REDACTED]

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

Agency: MNsure Board
Minnesota Department of Human Services

Docket: 154587

On October 29, 2014, Appeals Examiner Kelly A. Vargo 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,
Amy Jo Munson, 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 ISSUES

Whether the MNsure Board correctly determined that the Appellant is ineligible for enrollment in a QHP outside of the open enrollment period.

FINDINGS OF FACT

1. The MNsure Board (herein MNsure) advised the Appellant that the Appellant was ineligible for enrollment in a Qualified Health Plan (QHP), an advance payment of a premium tax credit and ineligible for cost-sharing reductions as provided in the Affordable Care Act. *Exhibit 2*. The Appellant filed a request challenging these determinations, which MNsure received on July 15, 2014. *Id.* An evidentiary hearing was scheduled for August 20, 2014 but was continued pursuant to the agreement of the parties. An evidentiary hearing was scheduled for September 24, 2014 but was continued pursuant to the agreement of the parties. On October 29, 2014, Appeals Examiner Kelly A. Vargo held an evidentiary hearing via telephone conference. The judge accepted into evidence three exhibits.¹ The record was closed on October 29, 2014.

2. The Appellant applied for a health care insurance affordability programs for himself on the MNsure Eligibility System on October 25, 2013. *Exhibit 2*. MNsure determined Appellant met the eligibility requirement for an “unassisted” qualified health plan. *Id.* On December 10, 2013 Appellant enrolled into a Medica health plan and on December 12, 2013 Appellant enrolled in a Preferred One health plan. *Id.* On December 16, 2013 Appellant enrolled in Preferred One Ultimate Choice health plan. *Testimony of Munson*. Appellant requested that he only be enrolled in Preferred One Ultimate Select health plan and MNsure made the correct and requested Medical cancel his enrollment. *Exhibit 2 and Testimony of Munson*. Appellant was enrolled in Preferred One Ultimate Select from January 1, 2014 through March 8, 2014. *Id.* On April 29, 2014, Appellant was sent notice from the health plan that his coverage was terminated effective March 8, 2014 for non-payment. *Testimony of Munson*. Appellant seeks to re-enroll in a health plan but is not eligible because failure to make premium payments is not a life triggering event and MNsure’s open enrollment period begins again on November 15, 2014. *Id.*

3. Appellant contends he did not pay the entire premium amount because he was billed for Preferred One Ultimate Choice but did not want that coverage. *Id.* Appellant also subtracted the amount of his tax credit amount each month before he was notified he was eligible for a tax credit. *Id.* Appellant does not dispute eligibility in a qualified health plan. *Id.* Appellant admits he enrolled in various health plans because he was confused. *Id.*

¹ Appellant’s Appeal Request, Exhibit 1; Agency’s Appeal Summary, Exhibit 2; Agency’s Appeal Summary Exhibit 3.

Appellant contends he wants Preferred One Ultimate Select because the premium is less than Preferred One Ultimate Choice. *Id.*

APPLICABLE LAW

4. For Medical Assistance and MinnesotaCare appeals, a person may request a state fair hearing by filing an appeal either: 1) within 30 days of receiving written notice of the action; or 2) within 90 days of such notice if the Appellant can show good cause why the request for an appeal was not submitted within the 30 day time limit. *Minn. Stat. § 256.045, subd. 3(h); Minn. Stat. § 256L.10.* For MNsure appeals, an appeal must be received within 90 days from the date of the notice of eligibility determination. *45 C.F.R. § 155.520(b)(1); Minn. R. 7700.0105, subp. 2(D).*

5. 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.*

6. Minn. R. 7700.0105, subp. 1(A) provides that 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) in response to a notice from MNsure under Code of Federal Regulations,

title 45, section 155.310 (h), 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) in response to a denial of a request to vacate a dismissal.

7. 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.² 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.

8. Effective January 1, 2014, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any lifetime or annual limit on the dollar amount of essential health benefits³ for any individual. *45 C.F.R. § 147.126(a)(1) & (2)*. A health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) is not subject to the prohibition against annual limits, set forth in paragraph (a)(2)(i) of this section. *Id.* at (a)(2)(ii). A group health plan, or a health insurance issuer offering group or individual health insurance coverage, may place annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable Federal or State law. *Id.* at (b)(1). The rules regarding lifetime and annual limits do not prevent a small group health plan, or a health insurance issuer offering group or individual health insurance coverage, from excluding all benefits for a condition. *45 C.F.R. § 147.126(b)(2)*. However, if any benefits are provided for a condition, then the prohibition against lifetime or annual limits on the dollar amount of essential health benefits applies. *Id.* Other requirements of Federal or State law may require coverage of certain benefits. *Id.*

² 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)).

³ Effective January 1, 2014, non-grandfather individual and small group plan must offer a package of essential health benefits. Essential health benefits under the Affordable Care Act include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. *42 U.S.C. § 18022*. Large employer plans are not required to offer the essential health benefits package regardless of whether or not they are grandfathered.

9. 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 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;⁴ or

⁴Pursuant to HHS Centers for Medicare & Medicaid Services (CMS) Guidance dated May 2, 2014 (“Special Enrollment Periods and Hardship Exemptions for Persons Meeting Certain Criteria”) hardship exemptions were granted for persons who obtained coverage that was effective May 1, 2014. Special enrollment periods were authorized for individuals eligible for or enrolled in COBRA and for individuals whose individual market plans are renewing outside of open enrollment. Special enrollment periods and hardships exemptions were authorized for AmeriCorps/VISTA/National Civilian Community Corps members. See: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf>

CMS Guidance dated March 24, 2014, authorizes special enrollment period consideration for consumers facing exceptional circumstances such as a natural disaster, medical emergency or a planned system outage which occurs on or around plan selection deadlines and for misrepresentation, misinformation, errors or inaction on the part of the Exchange, Navigators, or QHPs. See: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf>

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.

CONCLUSIONS OF LAW

10. This appeal is timely under 45 C.F.R §155.520(b) and Minn. R. 7700.0105, subp. 2(D).

11. The Appellant applied for affordable health insurance programs for himself on October 25, 2013. Appellant enrolled in three different qualified health plans. MNSure corrected Appellant's mistake and enrolled Appellant in Preferred One Ultimate Select. Appellant failed to make his premium payments and on March 8, 2014 he was terminated from the health plan. Appellant seeks to re-enroll in a qualified health plan. Pursuant to 45 C.F.R. § 155.420(d) set forth above, MNSure must allow the Appellant to enroll in a QHP outside the open enrollment period. However, failing to make premium payments does not meet the other special enrollment period criteria set forth in 45 C.F.R. § 155.420 or in the CMS Guidance, cited above. Accordingly, MNSure correctly determined that the Appellant was not eligible for enrollment in a QHP, with government assistance (APTC and cost-sharing reductions) or without, outside the 2014 open enrollment period. This is effective March 8, 2014.

12. It is noted that open enrollment for QHPs for the 2015 benefit year runs from November 15, 2014, through February 15, 2015, should the Appellant wish to enroll in unassisted coverage. *45 C.F.R. § 155.410(e)*.

RECOMMENDED ORDER

THE APPEALS EXAMINER RECOMMENDS THAT:

- The MNsure Board AFFIRM the determination that the Appellant is ineligible for enrollment in a QHP outside the open enrollment period effective March 8, 2014.

Kelly. A Vargo
Appeals Examiner

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 - 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.

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.