



**DECISION
OF AGENCY
ON APPEAL**

In the Appeal of: [REDACTED]
For: Qualified Health Plan
Agency: MNsure Board
Docket: 162887

On June 10, 2015 Appeals Examiner Deborah L. Johnson held an evidentiary hearing under 42 U.S.C. §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, I recommend the following findings of fact, conclusions of law, and order.

STATEMENT OF ISSUE

Whether the appellant is entitled to an Order granting her reimbursement of medical costs that she has incurred that are not covered by her current healthplan.

FINDINGS OF FACT

1. On February 20, 2014, the appellant submitted an application for healthcare coverage for herself through the MNsure eligibility system during a special open enrollment period. On April 23, 2015, the appellant submitted an appeal. An evidentiary hearing was conducted by telephone on June 10, 2015. The record, consisting of the Appeals Memorandum was closed on that date.

2. On February 20, 2015, the appellant contacted MNsure asking questions about the available plans and finding doctors through the network. MNsure provided information as to how to locate this information through the website or recommended that she contact the carrier directly. MNsure also provided the names of brokers in her area who could assist her.

3. On February 20, 2015, the appellant was manually enrolled in MNsure in a qualified health plan (QHP). Specifically, she was enrolled in Blue Cross Blue Shield (BCBS).

4. The appellant acknowledged that she missed the original deadline to enroll in a QHP because she was uncertain if she wanted to obtain coverage that way. She learned of a special enrollment period from a friend and only had a few hours to enroll before the enrollment date closed. She did not have time to consult a broker. She acknowledged that she received a Certificate of Coverage from BCBS but neither she nor her husband understood many of the provisions in the coverage booklet. *Testimony of Ms. [REDACTED]*

5. After the appellant enrolled, she required immediate attention to address a hiatal hernia. Because the appellant has had gastric bypass surgery, she had to see bariatric surgeon. She sought services through Essentia, an out-of-network provider. The appellant did not seek prior authorization for services through Essentia and did not realize that she was required to do so. *Id.*

6. The appellant believes that the communication was so poor regarding her plan benefits that she was unable to make an accurate decision regarding her enrollment. As a result, she has incurred significant medical costs related to the hiatal hernia treatment that have not been covered because of the terms of the BCBS plan. The appellant is requesting that the Appeals Examiner order some type of equitable relief in minimizing the outstanding medical bills. *Id.*

CONCLUSIONS OF LAW

1. This appeal is timely under 45 C.F.R. §155.520(b).
2. The MNsure Board would typically have the legal authority to review and decide this appeal under Minnesota Statute §62V.05, subdivision 6. As that provision allows, the MNsure Board has an agreement with the Department of Human Services to hear and decide certain MNsure appeals. In addition, the Commissioner of Human Services typically exercises jurisdiction over this appeal under Minn. Stat. § 256.045, subd. 3.
3. The MNsure Board and the Minnesota Department of Human Services lack jurisdiction over the appellant's appeal under Minn. Stat. §62V.05, Subd. 6(a). Pursuant to Minn. R. 7700.0105, Subpart 1, 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, made in accordance with Code of Federal Regulations, title 45, sections 155.305, (a) and (b); 155.330; and 155.335;
- (2) initial determinations and redeterminations made by MNsure of eligibility for and level of advanced payment of premium tax credit, and eligibility for and level of cost sharing reductions, made in accordance with Code of Federal Regulations, title 45, sections 155.305 (f) to (g); 155.330; and 155.335;
- (3) initial determinations and redeterminations made by MNsure of employer eligibility to purchase coverage for qualified employees through the Small Business Health Options Program under Code of Federal Regulations, title 45, section 155.710 (a);
- (4) initial determinations and redeterminations made by MNsure of employee eligibility to purchase coverage through the Small Business Health Options Program under Code of Federal Regulations, title 45, section 155.710 (e);
- (5) initial determinations and redeterminations made by MNsure of individual eligibility for an exemption from the individual responsibility requirement made in accordance with Code of Federal Regulations, title 45, section 155.605;
- (6) a failure by MNsure to provide timely notice of an eligibility

determination in accordance with Code of Federal Regulations, title 45, sections 155.310 (g); 155.330 (e)(1)(ii); 155.335 (h)(ii); 155.610 (i); and 155.715 (e) and (f);

(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 made according to this chapter and in accordance with Code of Federal Regulations, title 45, section 155.530 (d)(2).

5. In this case, the appellant applied for and was properly enrolled in a QHP during a special open enrollment period. The appellant is requesting that the Appeals Examiner create a form of equitable relief to provide for payment of some of the medical bills she has incurred on the grounds that she did not understand that she needed to secure prior authorization before going out-of-network, she did not understand the Certificate of Coverage and did not have sufficient time to research the ramifications of her plan choice. While the Appeals Examiner understands the appellant's concerns, there is no mechanism in the governing statutes and rules to create any type of equitable relief in this situation. *Minn. Stat. §62V.05, Subd. 6(a) and Minn. Rule 7700.0105, Subpart 1*. As such the appellant's appeal should be dismissed for lack of jurisdiction.

RECOMMENDED ORDER

THE APPEALS EXAMINER RECOMMENDS THAT:

The MNsure Board and the Commissioner of Human Services DISMISS the appellant's appeal for lack of jurisdiction.

Deborah L. Johnson
Appeals Examiner

Date

ORDER

IT IS THEREFORE ORDERED THAT based upon all the evidence and proceedings, the MNsure Board and the Commissioner 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

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.

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.

cc: [REDACTED], Appellant
Teresa Saybe, DHS 0838
Michael Turpin, MNsure General Counsel

