



**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: 173956

On March 30, 2016 Appeals Examiner Victoria M. Lemberger 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;
[REDACTED], Appellant's Advocate

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 (agency) correctly determined the Appellant was not eligible for an advance payment of the premium tax credit for January and February 2016.

FINDINGS OF FACT

1. On December 3, 2014, the appellant applied for health insurance as a two person household. *Exhibit 2*. MNsure eligibility system advised appellant that he was eligible for a qualified health plan (QHP) with \$286.93 per month in advance premium tax credits (APTC). *Id.* The appellant and his wife enrolled in a QHP. *Id.* The appellant did not authorize the agency to access their federal tax information (FTI). *Id.*

2. To prepare for the annual renewal, MNsure advised all persons who did not authorize the agency to access the FTI that applicants would have to renew his or her consent. *Id.* The appellant completed the authorization and sent it back to the agency. *Exhibit 1 and Appellant testimony.* The agency does not have a record of receiving the authorization. *Exhibit 2.* The appellant's coverage was renewed, without any APTC. *Id.* On February 22, 2016, the appellant reapplied for enrollment. *Id.* The appellant enrolled for coverage beginning on March 1, 2016 with an APTC of \$485.21 per month. *Id.*

3. Appellant received a premium bill for January and February 2016 with no APTC applied. *Appellant Testimony.* Appellant does not dispute the effective starting date of QHP coverage of January 1, 2016. *Id.*

4. On February 22, 2016, the appellant filed an appeal. *Exhibit 1.* I held an evidentiary hearing by telephone conference. The record, consisting of three exhibits, was closed at the end of the hearing.¹ At the hearing, appellant did not dispute the implicit determinations that appellant is ineligible for medical assistance and MinnesotaCare. *Exhibit 3.*

5. The appellant specifically recalls sending the authorization by first class mail and making the change to allow the agency access to the FTI prior to January 1, 2016. *Appellant testimony.* The letter was not returned as undeliverable. *Id.* He remembers it because he did not want to go through the FTI issue later and discussed it with Ms. [REDACTED] *Id.*

CONCLUSIONS OF LAW

1. This appeal is timely under 45 C.F.R. §155.520(b).

¹Exhibit 1 – Appeal; Exhibit 2 – MNsure Summary; Exhibit 3 – DHS Summary.

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, 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*.

3. In this case, the appellant does not disagree with the agency's determination concerning his eligibility for Medical Assistance and MinnesotaCare.

4. The agency does not dispute that the appellant is eligible for the APTC; rather, the argument is the correct effective date. It is well-established that a presumption of receipt by an addressee is created when the sender demonstrates proper mailing of the document through evidence of habit or custom coupled with some evidence that the procedures were complied with in the particular instance. The presumption is rebuttable by showing that the document was not, in fact received. *Nafstad v. Merchant*, 228 N.W.2d 548, 550 (Minn. 1975); see also *Thomas v. Fey*, 405 N.W.2d 450, 454 (Minn. App. 1987). Based on the sworn evidence of the appellant, I conclude that the agency received the renewal.

5. 45 C.F.R. §155.410(f)(2) says that for the benefit year beginning on January 1, 2016, the Exchange must ensure that coverage is effective —

(i) January 1, 2016, for QHP selections received by the Exchange on or before December 15, 2015.

(ii) February 1, 2016, for QHP selections received by the Exchange from December 16, 2015 through January 15, 2016.

(iii) March 1, 2016, for QHP selections received by the Exchange from January 16, 2016 through January 31, 2016.

6. Each year, the Exchange must determine the eligibility of consumers enrolled in QHP coverage through the marketplace. *45 C.F.R. §155.335(a)(1)*. Consumers who are determined eligible to enroll through the Exchange in a QHP in the individual market are "qualified individuals," or QIs. *45 C.F.R. § 155.20*.

7. 45 C.F.R. § 155.335(a)(2) provides that an Exchange has three options to redetermine eligibility for enrollment in a qualified health plan through the Exchange and insurance affordability programs on an annual basis:

- (i) The procedures described in paragraphs (b) through (m) of this section;
- (ii) Alternative procedures specified by the Secretary for the applicable benefit year;
or
- (iii) Alternative procedures approved by the Secretary based on a showing by the Exchange that the alternative procedures would facilitate continued enrollment in coverage for which the enrollee remains eligible, provide clear information about the process to the qualified individual or enrollee (including regarding any action by the qualified individual or enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections. *45 C.F.R. §155.335(a)(2)*.

8. The alternative procedures specified by the Secretary for 2016 coverage year are discussed in the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) April 22, 2015 Guidance. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf>.

9. Whether under the alternative procedure specified by the Secretary or the procedures described in paragraphs (b) through (m) of 45 C.F.R. § 155.335, the Exchange must have authorization from the qualified individual to obtain updated tax data for purposes of conducting the annual eligibility redetermination for APTC and income-based CSR. *45 C.F.R. § 155.335(k)(1)*; <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf>.

10. 45 C.F.R. § 155.335(l) provides that to the extent that a qualified individual has requested an eligibility determination for insurance affordability programs in accordance with §155.310(b) and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange must redetermine the qualified individual's eligibility only for enrollment in a QHP and notify the enrollee in accordance with the timing described in paragraph (d) of this section.

11. The April 22, 2015 Guidance is substantially similar to 45 C.F.R. §155.335(l). It provides that the Marketplace will discontinue the individual's eligibility for APTC and income-based CSR at the end of 2015 and re-enroll the enrollee in a QHP through the Marketplace for 2016 without APTC and income-based CSR, to the extent that the enrollee can be re-enrolled in accordance with 155.335(j), if the individual is enrolled in a QHP with APTC but did not authorize the Marketplace to request updated tax return information for use in the annual redetermination process and did not contact the Marketplace to obtain an updated eligibility determination by the deadline to select a QHP for coverage effective January 1, 2016. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf>.

12. The Exchange must provide a qualified individual with an annual redetermination notice including the following:

(3) The qualified individual's projected eligibility determination for the following year, after considering any updated information described in paragraph (b) of this section, including, if applicable, the amount of any advance payments of the premium tax credit and the level of any cost-sharing reductions or eligibility for Medicaid, CHIP or BHP. *45 C.F.R. § 155.335(c)*.

13. The April 22, 2015 Guidance also provides a similar notice provision, which says that:

Further, consistent with the alternative procedures specified by the Secretary for benefit year 2015, enrollees who are re-enrolled by the Marketplace will receive an eligibility determination notice and an enrollment confirmation message that explains the results of the annual eligibility redetermination and re-enrollment process.

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf>

14. Advance payments of the premium tax credit means payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the Affordable Care Act. *45 C.F.R. §155.20*.

15. 26 U.S.C. § 36B(a) provides that in the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

16. The term “premium assistance credit amount” means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to *all coverage months* of the taxpayer occurring during the taxable year. *26 U.S.C. § 36B(b)*.

17. The term “coverage month” means, with respect to an applicable taxpayer, any month if –

(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act). *26 U.S.C. § 36B(c)(2)*.

18. An applicable taxpayer (within the meaning of paragraph (b) of this section) is allowed a premium assistance amount only for any month that one or more members of the applicable taxpayer's family (the applicable taxpayer or the applicable taxpayer's spouse or dependent)—

- (1) Is enrolled in one or more qualified health plans through an Exchange; and
- (2) Is not eligible for minimum essential coverage (within the meaning of paragraph (c) of this section) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

26 C.F.R. §1.36B-2(a).

19. The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that –

(i) He or she 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 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(ii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse—

(A) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in paragraph (a) of this section; and

(B) Is 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-2(a)(2)* and (c). *45 C.F.R. § 155.305(f)*.

20. A taxpayer must reconcile the amount of credit allowed under section 36B with advance credit payments on the taxpayer's income tax return for a taxable year. *26 C.F.R. § 1.36B-4(a)(1)(i)*. A taxpayer whose premium tax credit for the taxable year exceeds the taxpayer's advance credit payments may receive the excess as an income tax refund. *26 C.F.R. § 1.36B-4(a)(1)(i)*. A taxpayer whose advance credit payments for the taxable year exceed the taxpayer's premium tax credit owes the excess as an additional income tax liability. *26 C.F.R. § 1.36B-4(a)(1)(i)*.

21. According to the Minnesota Department of Human Services Insurance Affordability Programs Manual, Section 400.20.05, eligibility, enrollment, and coverage begin dates are separate concepts for Advance Premium Tax Credit (APTC).

- The APTC and Cost Sharing Reduction (CSR) eligibility begin date is the first day of the month following the month the household is determined eligible.
- The date APTC is applied towards the cost of a health insurance plan and CSR is applied to cost sharing depends on when the household selects a health insurance plan and pays the first premium.
- Households must pay their premium before coverage can begin. APTC can be applied towards the cost of a health plan over the certification period, beginning the month the household enrolls through December 31 of each year.

Generally, coverage begins on January 1. The benefit year for APTC is from January 1 through December 31. During the benefit year, enrollment from the first through the 15th of the month provides coverage effective the first day of the next month. This is the first month APTC can be applied toward the cost of a health insurance plan and the first month CSR is applied to the health plan's cost sharing. Enrollment from the 16th through the end of the month provides coverage effective the month following the next month. *Insurance Affordability Programs Manual, Section 400.20.05.*

22. On February 27, 2014, the Department of Health & Human Services Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) issued a bulletin on the availability of retroactive advance premium tax credits (APTCs) and cost-sharing reductions (CSRs) under the Affordable Care Act with respect to individuals who were unable to enroll in a qualified health plan through the appropriate Exchange because of technical issues experienced by that Exchange's automated eligibility and enrollment functionality.²
<https://www.cms.gov/cciiio/resources/regulations-and-guidance/downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf>.

23. Two categories of affected individuals are described in the CCIIO Bulletin. First, individuals who have not been continuously enrolled in any coverage until they successfully enroll in coverage through the Exchange will be treated as having been enrolled in that QHP for all purposes retroactive to the date on which coverage would have been effective absent any technical issues with the Exchange. *Id.* Second, affected individuals who enroll in a QHP outside of an Exchange will be deemed to have enrolled in that coverage through the Exchange once they have successfully received a determination of eligibility for coverage through the Exchange. *Id.* In both cases, if the

² The Appeals Examiner finds that the guidance has persuasive value even though it was issued in 2014 concerning technical issues at that time.

individual is determined to be eligible for APTCs and CSRs, CMS will make appropriate payments to the QHP issuer for any months that fall within that retroactive coverage period. *Id.*

24. The February 27, 2014 CCIIO Bulletin provides the following:

In both of the situations described above, if an individual is determined eligible for retroactive CSRs or advance payments of the PTC, the issuer of the QHP will be required to adjudicate or re-adjudicate, as applicable, the enrollee's claims incurred during the retroactive period, and refund or credit to the enrollee any excess cost sharing or premiums paid if applicable, and ensure the provision of refunds or credits of any excess payments made by or for the enrollee for covered benefits and services incurred during the retroactive coverage period. Unless the individual requests the issuer provide a refund, the issuer may elect to provide a credit toward the individual's premium payment for each subsequent month for the remainder of the period of enrollment or benefit year until the credit is fully applied. Any refund or credit for any excess cost-sharing or premium paid for or on behalf of the individual must be provided (or begin to be provided in the case of a credit) within 45 calendar days of the date of discovery of the excess cost-sharing or premium paid, as detailed in 45 C.F.R. 156.410(c)(1). If a credit remains at the end of the period of enrollment or benefit year, the issuer must refund the enrollee any remaining excess cost sharing or premium paid by or for the enrollee within 45 calendar days of the end of the period of enrollment or benefit year, whichever comes first. *Id.*

25. It is unclear which procedure the Agency followed in this case with regards to the annual redetermination process. Nonetheless, the law is clear that eligibility for advance premium tax credits must be redetermined on an annual basis. In order to do this, the Agency must have authorization from enrollees to obtain their most recent tax information. The record in this case shows that the Agency had authority to access the Appellant's federal tax information by the deadline to select a QHP for coverage effective January 1, 2016. 45 C.F.R. §155.335(j) specifically directs that coverage must continue for qualified individuals (individuals eligible to enroll in a QHP). Therefore, I conclude that it was correct for the Agency to enroll the Appellant in a QHP effective January 1, 2016.

26. The more difficult question in this case is whether the Appellant is eligible for retroactive APTC. The regulation does not specifically address this issue. 26 U.S.C. § 36B however, clarifies that the amount of premium tax credits is dependent upon the number of "coverage months" the taxpayer has during a given tax year. In addition, the February 27, 2014 Guidance sets forth that retroactive APTCs is available to individuals who were unable to enroll in a QHP because of technical issues experienced by the Exchange's automated eligibility and enrollment functionality.

27. Advance premium tax credits are available so that individuals and families can receive help when they need it rather than having to wait until they file taxes. Considering the facts in this case, particularly uncontroverted evidence that the appellant sent the authorization in time for the agency to act upon it prior to January 1, 2016, the financial harm that the Appellant suffered, and the technical issues that gave rise to the FTI issue in the first place, I conclude that the Appellant's situation is of similar character to the circumstances discussed in the February 27, 2014 Guidance for which retroactive APTC is warranted. Therefore, I recommend that the Appellant be granted retroactive APTC beginning the coverage effective date of January 1, 2016.

RECOMMENDED ORDER

THE APPEALS EXAMINER RECOMMENDS THAT:

The MNsure Board REVERSE the Agency's determination that the Appellant's APTC is effective on March 1, 2016 and ORDER the Agency to apply APTC retroactive to January 1, 2016.

Victoria M. Lemberger
Appeals Examiner

Date

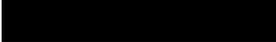
ORDER

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

cc: , Appellant
, Appellant's Advocate
MNSure General Counsel
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.
- **Seek judicial review** to the extent it is available by law.

If you disagree with the 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 that you must start *within 30 days of the date of this decision*. You start this proceeding by serving a notice of appeal upon the other parties and the Commissioner, and filing the original notice and proof of service with the county district court. The law that describes this process is Minnesota Statute § 256.045, subdivision 7.