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MEMORANDUM

July 23, 2013

To: Tribal Health Clients

From: Hobbs, Straus, Dean & Walker LLP

Re: *IRS Issues Notice Delaying ACA "Employer Mandate"; CMS Holds All Tribes' Call on Medicaid and CHIP State Plan Amendment Process*

IRS Issues Notice Formally Delaying ACA "Employer Mandate" Until 2015

As previously reported, the Internal Revenue Service ("IRS") announced that it will not be enforcing the requirement that all large employers provide health insurance coverage to their full time employees (the "employer mandate") until 2015. On July 9, the IRS issued a guidance notice formalizing this announcement.

IRS Notice 2013-45 provides one year of "transition relief" from certain employer and insurer reporting requirements and tax penalties, including the "employer mandate," that were scheduled to take effect in 2014. The IRS guidance states that the delay "will provide additional time for input from employers and other reporting entities in an effort to simplify information reporting consistent with effective implementation of the law."

The ACA "employer mandate" requires large employers (those with 50 or more full-time employees) to provide a minimum level of health coverage to their employees, or be subject to a "shared responsibility payment," or tax penalty. The IRS issued a proposed rule setting out those requirements earlier this year, which we summarized in our memorandum to Tribal Health Clients dated February 13, 2013. The IRS announced in its recent Notice that it intends to issue another proposed rule to implement the shared responsibility payment provisions sometime this summer.

According to the Notice, those proposed regulations will reflect an implementation date of 2015. Since assessment of the shared responsibility payment is based in part on information provided under the reporting requirements, the Notice states that no shared responsibility payments (i.e., tax penalties) will be assessed in 2014. However, employers are "encouraged to voluntarily comply" with the reporting provisions even during the transition relief period.

CMS All Tribes' Call on Medicaid and CHIP State Plan Amendments Process

The Tribal Affairs Group at the Centers for Medicare & Medicaid Services (CMS) hosted an All Tribes' Call on July 12, 2013, to discuss Medicaid and Children's Health Insurance Program (CHIP) State Plan Amendments (SPA). States are required to submit their SPA to CMS to implement changes required by the Affordable Care Act (ACA) going into effect in the coming months. States are required by Section 5006 of the American Recovery and Reinvestment Act to solicit advice from tribes prior to submission of any plan amendments likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian organizations. The purpose of the CMS call was to provide tribal leaders with background on some of the changes states will be required to make in their SPA so that tribes are prepared to consider these issues and respond when states seek their advice. CMS representatives on the call said that CMS is committed to ensuring that states engage in meaningful consultation with the tribes, even though CMS has promised states that it will review SPA submissions on an expedited basis.

CMS representatives began the call by providing background information on major changes to the Medicaid program under the ACA that will be going into effect in 2014, including Medicaid Expansion and other changes in Medicaid program operation. Under the ACA, starting in 2014 the Federal government will provide 100% Federal Medical Assistance Percentage (FMAP) funding for states that extend Medicaid eligibility to all adults up to 138% of the federal poverty level (FPL) for three years. After the first three years, the FMAP decreases, but never below 90%. Medicaid Expansion was meant to be mandatory in all states, but as a result of the Supreme Court's ruling on the ACA the Expansion is now optional. CMS representatives noted that states that do not choose to participate in the Medicaid Expansion in 2014 may join at any future date, and that states may also withdraw from participation at a later date. They reported that 23 states have already elected to participate but that others have not yet done so. If a state decides to participate in Medicaid Expansion, its SPA will need to reflect that change, and tribes should be consulted about that aspect of the SPA.

Also in 2014, a provision of the ACA requiring states to maintain Medicaid and CHIP eligibility standards at a consistent level – referred to as the Maintenance of Effort (MOE) provision – will expire. Expiration of the MOE provision will permit states to reduce Medicaid and CHIP eligibility, which could result in individuals currently eligible losing their coverage. CMS representatives reported that they do not expect many states to restrict eligibility, but that it is a possibility. If states make that choice, it must be reflected in the state's SPA, and tribes may be particularly interested in advising their states with respect to this policy choice.

Certain other changes to the Medicaid program will go into effect in every state, regardless of that state's decisions regarding Medicaid expansion or MOE. One of those changes is that states will be required to use a single "streamlined" application to

determine eligibility for Medicaid, CHIP, and enrollment in Qualified Health Plans through the Exchanges. States may use the model application developed by CMS (which solicited input from tribes in designing the application), or seek approval from CMS to use their own application. Other changes that will need to be reflected in a state's SPA include: how the state will establish Modified Adjusted Gross Income (MAGI)-based eligibility levels and implement the new MAGI income methodology; how the state will affirm residency regulations and address issues like temporary absence from the state; and how a state will comply with newly released regulations relating to Alternative Benefit Plans. Prior to the call, CMS distributed a list of SPA groups which includes those previously listed as well as several others. The list, which is attached to this memorandum, includes asterisks marking "key policy decisions" that the states must make. CMS recommends that tribes review the list and identify those issues likely to be most important to them when the state consults with the tribe about the SPA.

Any of these changes could have a significant impact on Tribal health programs. Therefore, it is critical to ensure that the States consult with you prior to submitting their SPAs to CMS. Please let us know if we may be of assistance in reviewing any changes to your State's Medicaid program through this process.

Conclusion

If you would like any assistance or further information regarding the topics discussed in this memorandum, please contact Elliott Milhollin at (202)822-8282 or emilhollin@hobbsstraus.com; Geoff Strommer at (503)242-1745 or gstrommer@hobbsstraus.com; or Caroline Mayhew at (202)822-8282 or cmayhew@hobbsstraus.com.

Transition Relief for 2014 Under §§ 6055 (§ 6055 Information Reporting), 6056 (§ 6056 Information Reporting) and 4980H (Employer Shared Responsibility Provisions)

NOT-129718-13

Notice 2013-45

I. PURPOSE AND OVERVIEW

This notice provides transition relief for 2014 from (1) the information reporting requirements applicable to insurers, self-insuring employers, and certain other providers of minimum essential coverage under § 6055 of the Internal Revenue Code (Code) (§ 6055 Information Reporting), (2) the information reporting requirements applicable to applicable large employers under § 6056 (§ 6056 Information Reporting), and (3) the employer shared responsibility provisions under § 4980H (Employer Shared Responsibility Provisions). This transition relief will provide additional time for input from employers and other reporting entities in an effort to simplify information reporting consistent with effective implementation of the law. This transition relief also is intended to provide employers, insurers, and other providers of minimum essential coverage time to adapt their health coverage and reporting systems. Both the information reporting and the Employer Shared Responsibility Provisions will be fully effective for 2015. In preparation for that, once the information reporting rules have been issued, employers and other reporting entities are encouraged to voluntarily comply with the information reporting provisions for 2014. This transition relief through 2014 for the information reporting and Employer Shared Responsibility Provisions has no effect on the effective date or application of other Affordable Care Act provisions.

II. BACKGROUND

Sections 6055, 6056, and 4980H were added to the Code by §§ 1502, 1514, and 1513, respectively, of the Patient Protection and Affordable Care Act (ACA), enacted March 23, 2010, Pub. L. No. 111-148.[1] Section 6055 requires annual information reporting by health insurance issuers, self-insuring employers, government agencies, and other providers of health coverage. Section 6056 requires annual information reporting by applicable large employers relating to the health insurance that the

[1] Section 4980H was amended by § 1003 of the Health Care and Education Reconciliation Act of 2010 (HCERA) (enacted March 30, 2010, Pub. L. No. 111-152) and was further amended by § 1858(b)(4) of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10). Section 6056 was amended by §§ 10106(g) and 10108(j) of the ACA and was further amended by § 1858(b)(5) of the Department of Defense and Full-Year Continuing Appropriations Act, 2011. In this notice, the term Affordable Care Act refers to the ACA and HCERA, collectively.

employer offers (or does not offer) to its full-time employees. Section 4980H(a) imposes an assessable payment on an applicable large employer that fails to offer minimum essential coverage to its full-time employees (and their dependents) under an eligible employer-sponsored plan if at least one full-time employee enrolls in a qualified health plan for which a premium tax credit is allowed or paid. Section 4980H(b) imposes an assessable payment on an applicable large employer that offers minimum essential coverage to its full-time employees (and their dependents) under an eligible employer-sponsored plan but has one or more full-time employees who enroll in a qualified health plan for which a premium tax credit is allowed or paid (for example, if the coverage offered either does not provide minimum value or is not affordable to that full-time employee).

III. TRANSITION RELIEF

Q-1. When will the rules be published regarding § 6055 Information Reporting and § 6056 Information Reporting? How will these provisions apply for 2014?

A-1. The Affordable Care Act requires information reporting under § 6055 by insurers, self-insuring employers, government agencies, and certain other parties that provide health coverage and requires information reporting under § 6056 by applicable large employers with respect to the health coverage offered to their full-time employees. Proposed rules for the information reporting provisions are expected to be published this summer. The proposed rules will reflect the fact that transition relief will be provided for information reporting under §§ 6055 and 6056 for 2014. This transition relief will provide additional time for dialogue with stakeholders in an effort to simplify the reporting requirements consistent with effective implementation of the law. It will also provide employers, insurers, and other reporting entities additional time to develop their systems for assembling and reporting the needed data. Employers, insurers, and other reporting entities are encouraged to voluntarily comply with these information reporting provisions for 2014 (once the information reporting rules have been issued) in preparation for the full application of the provisions for 2015. However, information reporting under §§ 6055 and 6056 will be optional for 2014; accordingly, no penalties will be applied for failure to comply with these information reporting provisions for 2014.

Q-2. What does the 2014 transition relief for § 6056 Information Reporting mean for application of the Employer Shared Responsibility Provisions for 2014?

A-2. Under the Employer Shared Responsibility Provisions, an applicable large employer generally must offer affordable, minimum value health coverage to its full-time employees or a shared responsibility payment may apply if one or more of its full-time employees receive a premium tax credit under § 36B. The § 6056 Information Reporting is integral to the administration of the Employer Shared Responsibility Provisions. In particular, because an employer typically will not know whether a full-time employee received a premium tax credit, the employer will not have all of the

information needed to determine whether it owes a payment under § 4980H. Accordingly, the employer is not required to calculate a payment with respect to § 4980H or file returns submitting such a payment. Instead, after receiving the information returns filed by applicable large employers under § 6056 and the information about employees claiming the premium tax credit for any given calendar year, the Internal Revenue Service (IRS) will determine whether any of the employer's full-time employees received the premium tax credit and, if so, whether an assessable payment under § 4980H may be due. If the IRS concludes that an employer may owe such an assessable payment, it will contact the employer, and the employer will have an opportunity to respond to the information the IRS provides before a payment is assessed.

For this reason, the transition relief from § 6056 Information Reporting for 2014 is expected to make it impractical to determine which employers owe shared responsibility payments for 2014 under the Employer Shared Responsibility Provisions. Accordingly, no employer shared responsibility payments will be assessed for 2014. However, in preparation for the application of the Employer Shared Responsibility Provisions beginning in 2015, employers and other affected entities are encouraged to voluntarily comply for 2014 with the information reporting provisions (once the information reporting rules have been issued) and to maintain or expand health coverage in 2014. Real-world testing of reporting systems and plan designs through voluntary compliance for 2014 will contribute to a smoother transition to full implementation for 2015.

Q-3. Does this affect employees' access to the premium tax credit?

A-3. No. Individuals will continue to be eligible for the premium tax credit by enrolling in a qualified health plan through the Affordable Insurance Exchanges (also called Health Insurance Marketplaces) if their household income is within a specified range and they are not eligible for other minimum essential coverage, including an eligible employer-sponsored plan that is affordable and provides minimum value.

Q-4. What does this mean for other provisions in the Affordable Care Act?

A-4. This transition relief through 2014 for § 6055 Information Reporting, § 6056 Information Reporting, and the Employer Shared Responsibility Provisions has no effect on the effective date or application of other Affordable Care Act provisions, such as the premium tax credit under § 36B and the individual shared responsibility provisions under § 5000A.

IV. DRAFTING INFORMATION

The principal author of this notice is Kathryn Johnson of the Office of Associate Chief Counsel (Tax Exempt & Government Entities). For further information regarding this notice contact Kathryn Johnson at (202) 927-9639 (not a toll-free call).

Medicaid and CHIP State Plan Amendments for 2014 – Eligibility and Benefits

SPA Group	Description
MAGI-based Eligibility Groups	**Mandatory:** Parents and Other Caretakers* Pregnant Women* Infants and Children Under Age 19 Individuals with Incomes Up to 133% of the FPL (New Adult Group)* Former Foster Care Children up to age 26
	Optional (only those that apply in state): Individuals Above 133% of the FPL Optional Parents and Caretakers* Reasonable Classifications of Individuals Non IV-E Adoption Assistance Optional Targeted Low Income Children Tuberculosis Foster Care Adolescents – Chafee Family Planning
	AFDC Income Standard
Eligibility Process	Single streamlined application or alternative,* Renewals, Coordination for enrollment and eligibility (agreements with Exchanges)
MAGI Income Methodology	Designates the income options the state is electing in 2014 (e.g. how pregnant women are counted, reasonably predictable changes in income, cash support, how full-time students are counted)*
Single State Agency	Addresses single state agencies delegation of appeals and determinations
Residency	State affirms residency regulations Addresses interstate agreements and temporary absence
Citizenship & Immigration Status	State affirms citizenship regulations, specifies reasonable opportunity options, and specifies policy options related to immigrant eligibility
Hospital Presumptive Eligibility	State specifies options for presumptive eligibility conducted by hospitals
Alternative Benefit Plans	Populations Enrolled in the ABP* Mapping of Essential Health Benefits* Other Benefits Provided to ABP Enrollees Assurances of Compliance with Requirements for Populations Otherwise Exempt from Mandatory ABP Enrollment* Service Delivery Options Payment Methodology

**Indicates those state plan amendments that involve key policy decisions for states.*

CHIP State Plan Amendments for 2014

SPA Group	Description
MAGI Eligibility & Methods	Set MAGI income standards for all covered groups in separate CHIP (by age & geographic area if appropriate): Targeted Low-income Children Targeted Low-income Pregnant Women Conception to birth Deemed newborns Children with access to public employee coverage Pregnant women with access to public employee coverage Dental only coverage MAGI Income Methodology
XXI Medicaid Expansion	Set MAGI-based income standards (all states) Establish new Medicaid eligibility group for 6 – 18 year olds with incomes between 100 – 133% of the FPL*
Establish 2101(f) group	Establish new coverage group for children who lose Medicaid eligibility as a result of discontinuation of disregards*
Eligibility Process	Single, Streamlined Application* Process for Assuring Coordination between Medicaid/CHIP Renewals Coordination with Other Insurance Affordability Programs
Non-Financial Eligibility	Residency Citizenship/Lawfully Residing Immigrants Social Security Number Premium Lock-Outs* CHIP Waiting Period* Other Eligibility Standards Continuous Eligibility Presumptive Eligibility – Children Presumptive Eligibility – Pregnant Women

**Indicates those state plan amendments that involve key policy decisions for states.*