

DATES: Withdrawal of approval is effective December 31, 2015.
FOR FURTHER INFORMATION CONTACT: Sujaya Dessai, Center for Veterinary Medicine (HFV-212), Food and Drug

Administration, 7519 Standish Pl., Rockville, MD 20855, 240-402-5761, sujaya.dessai@fda.hhs.gov.

SUPPLEMENTARY INFORMATION: Zoetis Inc., 333 Portage St., Kalamazoo, MI

49007 has requested that FDA withdraw approval of the following NADAs that provide for the use of nitarosone in medicated feed for chickens and turkeys because the products are no longer manufactured or marketed:

File No.	Product name	21 CFR Section
007-616	HISTOSTAT 50 (nitarosone) Type A Medicated Article	558.369
141-088	HISTOSTAT 50 (nitarosone)/BMD (bacitracin methylene disalicylate)	558.369
141-132	HISTOSTAT 50/ALBAC (bacitracin zinc)	558.369

Therefore, under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, and in accordance with 21 CFR 514.116 *Notice of withdrawal of approval of application*, notice is given that approval of NADAs 007-616, 141-088, and 141-132, and all supplements and amendments thereto, is hereby withdrawn, effective December 31, 2015.

Elsewhere in this issue of the **Federal Register**, FDA is amending the animal drug regulations to reflect the voluntary withdrawal of approval of these applications.

Dated: December 11, 2015.

Bernadette Dunham,
 Director, Center for Veterinary Medicine.
 [FR Doc. 2015-31828 Filed 12-17-15; 8:45 am]

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[TD 9745]

RIN 1545-BL43

Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations on the health insurance premium tax credit enacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended by the Medicare and Medicaid Extenders Act of 2010, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, and the Department of Defense and Full-Year Continuing Appropriations Act,

2011. These final regulations affect individuals who enroll in qualified health plans through Affordable Insurance Exchanges (Exchanges, sometimes called Marketplaces) and claim the health insurance premium tax credit, and Exchanges that make qualified health plans available to individuals and employers.

DATES: Effective Date: These regulations are effective on December 18, 2015.

Applicability Dates: For dates of applicability, see §§ 1.36B-1(o) and 1.36B-6(g).

FOR FURTHER INFORMATION CONTACT: For general questions on the premium tax credit, Shareen Pflanz, (202) 317-4718; for minimum value, Andrew Braden, (202) 317-7006 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

This document contains final regulations amending the Income Tax Regulations (26 CFR part 1) under section 36B of the Internal Revenue Code (Code) relating to the health insurance premium tax credit. Section 36B was enacted by the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act). Final regulations under section 36B (TD 9590) were published on May 23, 2012 (77 FR 30377) (2012 section 36B final regulations). On May 3, 2013, a notice of proposed rulemaking (REG-125398-12) was published in the **Federal Register** (78 FR 25909). Written comments responding to the proposed regulations were received. The comments have been considered in connection with these final regulations and are available for public inspection at www.regulations.gov or on request. No public hearing was requested or held. After consideration of all the comments, the proposed regulations are adopted, in part, as amended by this Treasury decision. Some rules proposed under REG-125398-12 on the minimum

value of eligible employer-sponsored plans have been reserved and will be finalized separately under REG-119850-15. Two paragraphs on minimum value have been re-proposed, see REG-143800-14 (80 FR 52678) (2015 proposed minimum value regulations), are finalized in part, and will be finalized in part under REG-143800-14.

Explanation of Revisions and Summary of Comments

1. Definition of Modified Adjusted Gross Income

Section 36B(d)(2) provides that a taxpayer's household income includes the modified adjusted gross income of the taxpayer and the members of the taxpayer's tax family who are required to file an income tax return. The 2012 section 36B final regulations provide that, in computing household income, whether a family member must file a tax return is determined without regard to section 1(g)(7). Under section 1(g)(7), a parent may elect to include a child's gross income in the parent's gross income if certain requirements are met.

The proposed regulations removed "without regard to section 1(g)(7)" from the 2012 section 36B final regulations because that language implied that the child's gross income is included in both the parent's adjusted gross income and the child's adjusted gross income in determining household income. Thus, the proposed regulations clarified that when a parent makes an election under section 1(g)(7), household income includes the child's gross income included on the parent's return only. These final regulations adopt that rule without change and clarify that the modified adjusted gross income of a parent who makes the section 1(g)(7) election includes the child's modified adjusted gross income. Thus, the parent's modified adjusted gross income includes not only the child's gross income but also the child's tax-exempt interest and nontaxable Social Security income, which are excluded from gross

income but included in modified adjusted gross income in computing household income. (A parent may not make a section 1(g)(7) election if the child has income excluded under section 911, the third type of nontaxable income included in modified adjusted gross income.)

2. Wellness Program Incentives

Under section 36B(c)(2)(C)(i) and § 1.36B-2(c)(3)(v), an eligible employer-sponsored plan is affordable for an employee and related individuals only if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage of the taxpayer's household income. Under section 36B(c)(2)(C)(ii), an eligible employer-sponsored plan provides minimum value only if the plan's share of the total allowed cost of benefits is at least 60 percent and, under the 2015 proposed minimum value regulations, the plan provides substantial coverage of inpatient hospital services and physician services.

The proposed regulations provide that, for an employee eligible to participate in a wellness program, the affordability and minimum value of eligible employer-sponsored coverage are determined by assuming that each employee fails to satisfy the requirements of a wellness program, except the requirements of a nondiscriminatory wellness program related to tobacco use. Thus, the affordability and minimum value of a plan that charges a higher initial premium or higher cost-sharing for tobacco users are determined based on the premium or cost-sharing that is charged to non-tobacco users or to tobacco users who complete the related wellness program, such as attending smoking cessation classes.

Identical rules, addressing only an employee's required contribution for purposes of determining affordability, were proposed in regulations under section 5000A (REG-141036-13, 79 FR 4302, January 27, 2014) (section 5000A proposed regulations). The preamble to regulations finalizing the section 5000A proposed regulations (TD 9705, 79 FR 70464, November 26, 2014) (section 5000A final regulations) discusses the comments received on the proposed regulations under section 36B, except comments discussed in the next paragraph, and additional comments received on the section 5000A proposed regulations (79 FR 70466). Comments discussed in the preamble to the section 5000A proposed regulations are not discussed again in this preamble.

Because the standard for affordability for individuals eligible for coverage by reason of a relationship to an employee (related individuals) under section 5000A is different than the standard under section 36B, the section 5000A final regulations do not address certain comments on the treatment of wellness program incentives in determining affordability for related individuals. These commenters requested that wellness incentives related to tobacco use be treated as unearned for related individuals. The commenters expressed concern that treating wellness incentives related to tobacco use as earned in all cases unfairly penalizes related individuals for an employee's tobacco use. However, section 36B(c)(2)(C) provides that the affordability of coverage for related individuals under section 36B is based on the cost of self-only coverage. Accordingly, the final regulations do not adopt this comment.

Thus, after considering all the comments, these final regulations, like the section 5000A final regulations, retain the rules in the proposed regulations that wellness incentives unrelated to tobacco use are treated as unearned and wellness incentives related to tobacco use are treated as earned in determining affordability. For purposes of both the section 5000A final regulations and these final regulations, nondiscriminatory wellness programs include both participatory and health-contingent wellness programs. Both the section 5000A final regulations and these final regulations also clarify that (1) a wellness incentive that includes any component unrelated to tobacco use is treated as unearned (however, as stated in the preamble to the section 5000A final regulations, if there is an incentive for completing a program unrelated to tobacco use and a separate incentive for completing a program related to tobacco use, then the incentive related to tobacco use may be treated as earned), and (2) the term *wellness program incentives* has the same meaning as the term *reward* in regulations issued by the Departments of Health and Human Services (HHS) and Labor as well as the Treasury Department, see § 54.9802-1(f), 29 CFR 2590.702(f), and 45 CFR 146.121(f). These final regulations also apply the rules described in this section of the preamble for purposes of determining minimum value.

3. Employer Contributions to Health Reimbursement Arrangements (HRA)

The proposed regulations provide that amounts newly made available in the current plan year under an HRA that is

integrated with eligible employer-sponsored coverage and that an employee may use to pay premiums are counted toward the employee's required contribution for purposes of determining affordability. Amounts newly made available in the current plan year under an HRA that is integrated with eligible employer-sponsored coverage and that an employee may use only to reduce cost-sharing for medical expenses covered by the primary plan count toward a plan's minimum value percentage.

The comments on the proposed regulations are discussed in the section 5000A final regulations. After considering all the comments, both the section 5000A final regulations and these final regulations (1) cross-reference Notice 2013-54 (2013-40 IRB 287, see § 601.601(d)) for guidance on the requirements for an HRA to be integrated with eligible employer-sponsored coverage, (2) clarify that amounts newly made available under an HRA reduce an employee's required contribution (or, for purposes of section 36B, count towards providing minimum value) if the HRA would have been integrated with eligible employer-sponsored coverage had the employee enrolled in the primary plan, (3) clarify that an HRA is taken into account in determining affordability (and minimum value for purposes of section 36B) only if the HRA and the primary eligible employer-sponsored coverage are offered by the same employer, (4) clarify that HRA contributions are taken into account for affordability and not minimum value if an employee may use the HRA contributions to pay premiums for the primary plan only or to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, and (5) clarify that employer contributions to an HRA reduce an employee's required contribution (or count towards providing minimum value for section 36B purposes) only to the extent the amount of the annual contribution is required under the terms of the plan or is otherwise determinable within a reasonable time before the employee must decide whether to enroll. For more information on how contributions to an HRA are taken into account for purposes of section 4980H(b) and related reporting under section 6056, see Notice 2015-87, 2015-52 IRB, released simultaneously with these final regulations.

Additional regulations will finalize other rules on minimum value in the proposed regulations.

4. Employer Contributions to Cafeteria Plans (Flex Contributions)

The preamble to the section 5000A proposed regulations requested comments on how employer contributions under a section 125 cafeteria plan (flex contributions) that employees may not opt to receive as a taxable benefit should be taken into account in determining an employee's required contribution for purposes of the affordability of coverage. The section 5000A final regulations discussed the comments received and adopted the rule that an employee's required contribution is reduced by employer contributions under a section 125 cafeteria plan that (1) may not be taken as a taxable benefit, (2) may be used to pay for minimum essential coverage, and (3) may be used only to pay for medical care within the meaning of section 213. These final regulations adopt this rule for purposes of determining affordability under section 36B.

For more information on the effect of flex contributions and other similar arrangements on affordability for purposes of sections 36B, 5000A, and related consequences under section 4980H, see Notice 2015-87, released simultaneously with these final regulations.

5. Post-Employment Coverage

Section 1.36B-2(c)(3)(iv) provides that an individual who may enroll in continuation coverage required under Federal law or a State law that provides comparable continuation coverage is eligible for minimum essential coverage only for months that the individual is enrolled in the coverage. The proposed regulations provide that this rule applies only to former employees and extend the rule to retiree coverage. Accordingly, an individual who may enroll in retiree coverage is eligible for minimum essential coverage only for the months the individual is enrolled in the coverage.

Commenters opined that the continuation and retiree coverage rules should apply to individuals eligible for the coverage by reason of a relationship to an employee, for example, the spouse of a retired employee. In response to these comments, the final regulations clarify that an individual who may enroll in continuation coverage or retiree coverage because of a relationship to a former employee is eligible for the coverage only for the months the individual is enrolled in the coverage.

Commenters suggested that the rule for continuation coverage should apply

to current employees eligible for continuation coverage as a result of reduced hours. The final regulations do not adopt this suggestion. Eligible employer-sponsored coverage for current employees does not present the same administrability issues as for former employees. Current employees with continuation coverage should be subject to the same general rules on eligibility for employer-sponsored coverage as other current employees. Although employees may be subject to a higher required contribution for continuation coverage than is required for other eligible employer-sponsored coverage, for purposes of the premium tax credit, employees are eligible for eligible employer-sponsored coverage only if the coverage is both affordable and provides minimum value. Thus, current employees offered continuation coverage, like other current employees, may be eligible for the premium tax credit if the coverage offered either is not affordable or does not provide minimum value.

6. Newborns, Adopted Children, and Other Individuals Enrolled Midmonth

Regulations at 45 CFR 155.420(d)(2)(i) require issuers to provide coverage to a newborn child enrolled in a qualified health plan effective on the date of birth. Under section 36B(c)(2)(A)(i) and § 1.36B-3(c)(1)(i), a month is a coverage month for an individual only if the individual is enrolled in a qualified health plan through an Exchange as of the first day of the month. Under § 1.36B-3(d), the monthly premium assistance amount is determined, in part, by the adjusted monthly premium for the applicable second lowest cost silver (benchmark) plan (benchmark plan premium). The proposed regulations provide that a child enrolled in a qualified health plan in the month of the child's birth, adoption, or placement with the taxpayer for adoption or in foster care (birth month) is treated as enrolled as of the first day of the month.

Some commenters interpreted the coverage month rule for newborns as requiring that issuers must provide coverage for a newborn as of the first day of the month.

Other commenters noted that applying a new adjusted monthly premium as of the first of the month, thus increasing the premium assistance amount for the month, is inconsistent with HHS regulations that provide that the amount of advance credit payments (which approximates the premium assistance amount) does not change until the first day of the month following the birth month.

No changes are made to the final regulations to reflect these comments. The rules treat certain individuals as enrolled as of the first day of the month for purposes of the premium tax credit to conform with the general rules for coverage months but do not require issuers to enroll the individuals as of the first day of the month. Furthermore, HHS regulations published on July 15, 2013 (78 FR 42321) removed the rule providing that advance credit payments do not change until the month following a birth or other event for which a midmonth enrollment is allowed.

Under 45 CFR 155.420(b)(2)(i), Exchanges must ensure that a taxpayer eligible to enroll an individual in coverage may choose for the individual's coverage to be effective as of the individual's date of birth, adoption, or placement for adoption or in foster care or as of the first day of the following month. Similarly, for individual's placed with a taxpayer by court order, 45 CFR 155.420(b)(2)(v) provides that Exchanges must allow the individual's coverage to be effective as of the date the court order is effective. Accordingly, the final regulations provide that an individual is treated as enrolled as of the first day of the month of birth, adoption, or placement in adoption or foster care if the individual's enrollment is effective as of the date of birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order. The final regulations use the term *individual* instead of *child* to align with HHS regulations relating to midmonth enrollments.

The proposed regulations provide that the adjusted monthly premium is determined as if all members of the coverage family for that month were enrolled in a qualified health plan for the entire month. The intent of this rule was to specify that the adjusted monthly premium is determined as of the first day of a coverage month and is not prorated for midmonth changes in enrollment or eligibility for other minimum essential coverage. Accordingly, an individual who enrolls midmonth but who is treated as enrolled as of the first day of the month is a member of the coverage family (if all other requirements are met) in determining the adjusted monthly premium for that month. For other coverage family changes, the adjusted monthly premium does not change until the following month. The final regulations clarify these rules by providing that the term *coverage family* means the members of a taxpayer's family for whom a month is a coverage month (which requires being enrolled

on the first day of the month) and that the adjusted monthly premium is determined as of the first day of a coverage month.

7. *Partial Months of Coverage*

The proposed regulations provide that the premium assistance amount for a coverage month is prorated by the number of days of coverage when a qualified health plan is terminated before the last day of a month and the issuer reduces or refunds a portion of the monthly premium.

The proposed rule for computing a prorated premium assistance amount has proven to be complex and may be difficult to administer. Accordingly, the final regulations provide that the premium assistance amount for a termination month is the lesser of (1) the enrollment premiums charged (reduced by any amounts that were refunded) and (2) the difference between the benchmark plan premium and contribution amount for the full month. The final regulations clarify that this computation also applies to a month an individual is enrolled in coverage effective on the date of the individual's birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order. The Treasury Department and the IRS anticipate publishing rules requiring Exchanges to report under section 36B(f)(3) for partial months of coverage the amount of enrollment premiums charged and advance credit payments made for the days of coverage and the benchmark plan premium for a full month of coverage.

Effective/Applicability Date

These final regulations apply to taxable years ending after December 31, 2013.

Special Analyses

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. Section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and, because the regulations do not impose a collection of information requirement on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Internal Revenue Code, the notice of proposed rulemaking that preceded these final regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for

comment on its impact on small business. No comments were received.

Drafting Information

The principal authors of these final regulations are Andrew Braden, Arvind Ravichandran, and Stephen J. Toomey of the Office of Associate Chief Counsel (Income Tax and Accounting). However, other personnel from the IRS and the Treasury Department participated in their development.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

■ **Paragraph 1.** The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par. 2.** Section 1.36B-0 is amended by:

- 1. Revising the introductory text.
- 2. Revising the entries for §§ 1.36B-2(c)(3)(iv) and 1.36B-2(c)(3)(v)(A)(4).
- 2. Adding entries for §§ 1.36B-2(c)(3)(v)(A)(5) and (6).
- 3. Revising the entries for §§ 1.36B-3(c)(2) and (3).
- 4. Adding entries for §§ 1.36B-3(c)(4), 1.36B-3(d)(1) and (2), 1.36B-3(d)(2)(i) and (ii) and 1.36B-6.

The revisions and additions read as follows:

§ 1.36B-0 Table of contents.

This section lists the captions contained in §§ 1.36B-1 through 1.36B-6.

* * * * *

§ 1.36B-2 Eligibility for premium tax credit.

* * * * *

- (c) * * *
- (3) * * *
- (iv) Post-employment coverage.
- (v) * * *
- (A) * * *
- (4) Wellness program incentives.
- (5) Employer contributions to health reimbursement arrangements.
- (6) Employer contributions to cafeteria plans.

* * * * *

§ 1.36B-3 Computing the premium assistance credit amount.

* * * * *

- (c) * * *
- (2) Certain individuals enrolled during a month.

- (3) Premiums paid for a taxpayer.
- (4) Examples.
- (d) * * *
- (1) In general.
- (2) Partial month of coverage.
- (i) In general.
- (ii) Examples.

* * * * *

§ 1.36B-6 Minimum value.

- (a) In general.
- (b) MV standard population.
- (c) MV percentage.
- (1) In general.
- (2) Wellness program incentives.
- (i) In general.
- (ii) Example.
- (3) Employer contributions to health savings accounts.
- (4) Employer contributions to health reimbursement arrangements.
- (5) Expected spending adjustments for health savings accounts and health reimbursement arrangements.
- (d) Methods for determining MV.
- (e) Scope of essential health benefits and adjustment for benefits not included in MV Calculator.
- (f) Actuarial certification.
- (1) In general.
- (2) Membership in American Academy of Actuaries.
- (3) Actuarial analysis.
- (4) Use of MV Calculator.
- (g) Effective/applicability date.
- (1) In general.
- (2) Exception.

■ **Par. 3.** Section 1.36B-1 is amended by revising paragraphs (e)(1)(i), (e)(1)(ii)(B), and (n) to read as follows:

§ 1.36B-1 Premium tax credit definitions.

* * * * *

- (e) * * *
- (1) * * *
- (i) A taxpayer's modified adjusted gross income (including the modified adjusted gross income of a child for whom an election under section 1(g)(7) is made for the taxable year);
- (ii) * * *
- (B) Are required to file a return of tax imposed by section 1 for the taxable year.

* * * * *

(n) *Rating area.* The term *rating area* has the same meaning as used in section 2701(a)(2) of the Public Health Service Act (42 U.S.C. 300gg(a)(2)) and 45 CFR 147.102(b).

* * * * *

■ **Par. 4.** Section 1.36B-2 is amended by:

- 1. Revising paragraphs (c)(3)(iv) and (c)(3)(v)(A)(4).
- 2. Adding paragraphs (c)(3)(v)(A)(5) and (6) and (c)(3)(v)(D), *Example 9*.
- 3. Revising paragraph (c)(3)(vi).

The revisions and additions read as follows:

§ 1.36B-2 Eligibility for premium tax credit.

* * * * *

(c) * * *
(3) * * *

(iv) *Post-employment coverage.* A former employee (including a retiree), or an individual related (within the meaning of paragraph (c)(3)(i) of this section) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under Federal law or a State law that provides comparable continuation coverage is eligible for minimum essential coverage under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(v) * * *
(A) * * *

(4) *Wellness program incentives.* Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this section, the term *wellness program incentive* has the same meaning as the term *reward* in § 54.9802-1(f)(1)(i) of this chapter.

(5) *Employer contributions to health reimbursement arrangements.* Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in Notice 2013-54 (2013-40 IRB 287) (see § 601.601(d) of this chapter), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the

employee must decide whether to enroll in the eligible employer-sponsored plan.

(6) *Employer contributions to cafeteria plans.* Amounts made available for the current plan year under a cafeteria plan, within the meaning of section 125, reduce an employee's or a related individual's required contribution if—

(i) The employee may not opt to receive the amount as a taxable benefit;
(ii) The employee may use the amount to pay for minimum essential coverage; and

(iii) The employee may use the amount exclusively to pay for medical care, within the meaning of section 213.

* * * * *

(D) * * *

Example 9. Wellness program incentives.

(i) Employer X offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by \$300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by \$200 if an employee completes cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and the cost of his premiums is \$3,700. Employee C uses tobacco and the cost of her premiums is \$4,000.

(ii) Under paragraph (c)(3)(v)(A)(4) of this section, only the incentives related to tobacco use are counted toward the premium amount used to determine the affordability of X's plan. C is treated as having earned the \$300 incentive for attending a smoking cessation course regardless of whether C actually attends the course. Thus, the required contribution for determining affordability for both Employee B and Employee C is \$3,700. The \$200 incentive for completing cholesterol screening is treated as not earned and does not reduce their required contribution.

(vi) *Minimum value.* See § 1.36B-6 for rules for determining whether an eligible employer-sponsored plan provides minimum value.

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■ **Par. 5.** Section 1.36B-3 is amended by:

- 1. Revising paragraph (b)(2).
- 2. Redesignating paragraphs (c)(2) and (3) as paragraphs (c)(3) and (4) and adding paragraph (c)(2).
- 3. Revising paragraph (d).
- 4. Adding a sentence to the end of paragraph (e).
- 5. Revising paragraphs (f)(4), (g)(2), and (j)(1) and (3).
- 6. Removing the language “(d)(1)” everywhere it appears in paragraphs (h), (j), and (k), and adding the language “(d)(1)(i)” in its place and removing the language “(d)(2)” everywhere it appears in paragraphs (h) and (j) and adding the language “(d)(1)(ii)” in its place.

The revisions and additions read as follows:

§ 1.36B-3 Computing the premium assistance credit amount.

* * * * *

(b) * * *

(2) The term *coverage family* means, in each month, the members of a taxpayer's family for whom the month is a coverage month.

(c) * * *

(2) *Certain individuals enrolled during a month.* If an individual enrolls in a qualified health plan and the enrollment is effective on the date of the individual's birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order, the individual is treated as enrolled as of the first day of that month for purposes of this paragraph (c).

* * * * *

(d) *Premium assistance amount—*(1) *In general.* Except as provided in paragraph (d)(2) of this section, the premium assistance amount for a coverage month is the lesser of—

(i) The premiums for the month for one or more qualified health plans in which a taxpayer or a member of the taxpayer's family enrolls (enrollment premiums); or

(ii) The excess of the adjusted monthly premium for the applicable benchmark plan (benchmark plan premium) over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year (the taxpayer's contribution amount).

(2) *Partial month of coverage—*(i) *In general.* If a qualified health plan is terminated before the last day of a month or an individual is enrolled in coverage effective on the date of the individual's birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order, the premium assistance amount for the month is the lesser of—

(A) The enrollment premiums for the month (not including any amounts that were refunded); or

(B) The excess of the benchmark plan premium for a full month of coverage over the full contribution amount for the month.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (d)(2).

Example 1. (i) Taxpayer R is single and has no dependents. R enrolls in a qualified health plan with a monthly premium of \$450. The difference between R's benchmark plan premium and contribution amount for the month is \$420. R's premium assistance amount for a coverage month with a full month of coverage is \$420 (the lesser of \$450 and \$420).

(ii) The issuer of R's qualified health plan is notified that R died on September 20. The

issuer terminates coverage as of that date and refunds the remaining portion of the September enrollment premiums (\$150) for R's coverage.

(iii) Under this paragraph (d)(2), R's premium assistance amount for September is the lesser of the enrollment premiums for the month (\$300 (\$450—\$150)) or the difference between the benchmark plan premium for a full month of coverage and the full contribution amount for the month (\$420). R's premium assistance amount for September is \$300, the lesser of \$420 and \$300.

Example 2. The facts are the same as in *Example 1* of this paragraph (d)(2)(ii), except that the qualified health plan issuer does not refund any enrollment premiums for

September. Under this paragraph (d)(2), R's premium assistance amount for September is \$420, the lesser of \$450 and \$420.

Example 3. The facts are the same as in *Example 1* of this paragraph (d)(2)(ii), except that the difference between R's benchmark plan premium and contribution amount for a month is \$275. Accordingly, R's premium assistance amount for a coverage month with a full month of coverage is \$275 (the lesser of \$450 and \$275). Under this paragraph (d)(2), R's premium assistance amount for September remains \$275, the lesser of \$300 and \$275.

(e) * * * The adjusted monthly premium for a coverage month is

determined as of the first day of the month.

(f) * * *
 (4) *Family members residing at different locations.* The benchmark plan premium determined under paragraphs (f)(1) and (2) of this section for family members who live in different States and enroll in separate qualified health plans is the sum of the premiums for the applicable benchmark plans for each group of family members living in the same State.

* * * * *
 (g) * * *
 (2) *Applicable percentage table.*

Household income percentage of Federal poverty line	Initial percentage	Final percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but not more than 400%	9.5	9.5

* * * * *
 (j) *Additional benefits—(1) In general.* If a qualified health plan offers benefits in addition to the essential health benefits a qualified health plan must provide under section 1302 of the Affordable Care Act (42 U.S.C. 18022), or a State requires a qualified health plan to cover benefits in addition to these essential health benefits, the portion of the premium for the plan properly allocable to the additional benefits is excluded from the monthly premiums under paragraph (d)(1)(i) or (ii) of this section. Premiums are allocated to additional benefits before determining the applicable benchmark plan under paragraph (f) of this section.

(3) *Examples.* The following examples illustrate the rules of this paragraph (j):

Example 1. (i) Taxpayer B enrolls in a qualified health plan that provides benefits in addition to essential health benefits (additional benefits). The monthly premiums for the plan in which B enrolls are \$370, of which \$35 is allocable to additional benefits. B's benchmark plan premium (determined after allocating premiums to additional benefits for all silver level plans) is \$440, of which \$40 is allocable to additional benefits. B's monthly contribution amount, which is the product of B's household income and the applicable percentage, is \$60.

(ii) Under this paragraph (j), B's enrollment premiums and the benchmark plan premium are reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, B's monthly enrollment premiums are reduced to \$335 (\$370 - \$35) and B's benchmark plan premium is reduced to \$400 (\$440 - \$40). B's premium assistance amount for a

coverage month is \$335, the lesser of \$335 (B's enrollment premiums, reduced by the portion of the premium allocable to additional benefits) and \$340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits (\$400), minus B's \$60 contribution amount).

Example 2. The facts are the same as in *Example 1* of this paragraph (j)(3), except that the plan in which B enrolls provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under paragraph (j) of this section, B's benchmark plan premium (\$440) is reduced by the portion of the premium allocable to additional benefits provided under that plan (\$40). B's enrollment premiums (\$370) are not reduced under this paragraph (j). B's premium assistance amount for a coverage month is \$340, the lesser of \$370 (B's enrollment premiums) and \$340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits (\$400), minus B's \$60 contribution amount).

* * * * *
■ Par. 6. Section 1.36B-6 is added to read as follows:

§ 1.36B-6 Minimum value.

(a) *In general.* An eligible employer-sponsored plan provides minimum value (MV) only if—

- (1) The plan's share of the total allowed costs of benefits provided to an employee (the MV percentage) is at least 60 percent; and
- (2) [Reserved]

(b) *MV standard population.*

[Reserved]

(c) *MV percentage—(1) In general.*

[Reserved]

(2) *Wellness program incentives—(i) In general.* Nondiscriminatory wellness

program incentives offered by an eligible employer-sponsored plan that affect deductibles, copayments, or other cost-sharing are treated as earned in determining the plan's MV percentage if the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this section, the term *wellness program incentive* has the same meaning as the term *reward* in § 54.9802-1(f)(1)(i) of this chapter.

(ii) *Example.* The following example illustrates the rules of this paragraph (c)(2):

Example. (i) Employer X offers an eligible employer-sponsored plan that reduces the deductible by \$300 for employees who do not use tobacco products or who complete a smoking cessation course. The deductible is reduced by \$200 if an employee completes cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and his deductible is \$3,700. Employee C uses tobacco and her deductible is \$4,000.

(ii) Under paragraph (c)(2)(i) of this section, only the incentives related to tobacco use are considered in determining the plan's MV percentage. C is treated as having earned the \$300 incentive for attending a smoking cessation course regardless of whether C actually attends the course. Thus, the deductible for determining for the MV percentage for both Employees B and C is \$3,700. The \$200 incentive for completing cholesterol screening is disregarded.

(3) *Employer contributions to health savings accounts.* Employer

contributions for the current plan year to health savings accounts that are offered with an eligible employer-sponsored plan are taken into account for that plan year towards the plan's MV percentage.

(4) *Employer contributions to health reimbursement arrangements.* Amounts newly made available for the current plan year under a health reimbursement arrangement that would be integrated within the meaning of Notice 2013–54 (2013–40 IRB 287), see § 601.601(d) of this chapter, with an eligible employer-sponsored plan for an employee enrolled in the plan are taken into account for that plan year towards the plan's MV percentage if the amounts may be used to reduce only cost-sharing for covered medical expenses. A health reimbursement arrangement counts toward a plan's MV percentage only if the health reimbursement arrangement and the eligible employer-sponsored plan are offered by the same employer. Employer contributions to a health reimbursement arrangement count for a plan year towards the plan's MV percentage only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(5) *Expected spending adjustments for health savings accounts and health reimbursement arrangements.*

[Reserved]

(d) *Methods for determining MV.*
[Reserved]

(e) *Scope of essential health benefits and adjustment for benefits not included in MV Calculator.* [Reserved]

(f) *Actuarial certification.* [Reserved]

(1) *In general.* [Reserved]

(2) *Membership in American Academy of Actuaries.* [Reserved]

(3) *Actuarial analysis.* [Reserved]

(4) *Use of MV Calculator.* [Reserved]

(g) *Effective/applicability date—in general.* (1) Except as provided in paragraph (g)(2) of this section, this section applies for taxable years ending after December 31, 2013.

(2) *Exception.* [Reserved]

■ **Par. 7.** Section 1.6011–8 is amended by revising paragraph (a) to read as follows:

§ 1.6011–8 Requirement of income tax return for taxpayers who claim the premium tax credit under section 36B.

(a) *Requirement of return.* A taxpayer for whom advance payments of the premium tax credit under section 36B are made in a taxable year must file an income tax return for that taxable year

on or before the due date for the return (including extensions of time for filing).

* * * * *

John Dalrymple,

Deputy Commissioner for Services and Enforcement.

Approved: December 11, 2015

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

[FR Doc. 2015–31866 Filed 12–16–15; 4:15 pm]

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DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Parts 1902, 1903, 1904, 1952, 1953, 1954, 1955, and 1956

[Docket No. OSHA–2014–0009]

RIN 1218–AC76

Streamlining of Provisions on State Plans for Occupational Safety and Health

AGENCY: Occupational Safety and Health Administration (OSHA), Department of Labor.

ACTION: Final rule; confirmation of effective date; approval of collections of information under the Paperwork Reduction Act of 1995.

SUMMARY: On August 18, 2015 OSHA published in the **Federal Register** a direct final rule that streamlined provisions on State Plans. OSHA stated in that document that it would withdraw the companion proposed rule and confirm the effective date of the final rule if the Agency received no significant adverse comments on the direct final rule or the proposal. Since OSHA received no comments on the direct final rule or the proposal, the Agency now confirms that the direct final rule became effective as a final rule on October 19, 2015. The proposed rule and the direct final rule also requested comments on the collections of information contained in State Plan regulations under the Paperwork Reduction Act of 1995. The Office of Management and Budget (OMB) approved those collections of information.

DATES: The effective date for the direct final rule that published on August 18, 2015 (80 FR49897) is confirmed as October 19, 2015.

ADDRESSES: Electronic copies of this **Federal Register** notice are available at <http://www.regulations.gov>. This

Federal Register notice, as well as news releases and other relevant information, also are available at OSHA's Web page at <http://www.osha.gov>.

FOR FURTHER INFORMATION CONTACT: *For press inquiries:* Francis Meilinger, Director, OSHA Office of Communications, Room N–3647, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210; telephone: (202) 693–1999; email: meilinger.francis2@dol.gov.

For general and technical information: Douglas J. Kalinowski, Director, OSHA Directorate of Cooperative and State Programs, Room N–3700, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210; telephone: (202) 693–2200; email: kalinowski.doug@dol.gov.

SUPPLEMENTARY INFORMATION:

Confirmation of the effective date: On August 18, 2015, OSHA published a direct final rule in the **Federal Register** amending OSHA regulations to remove the detailed descriptions of State Plan coverage, purely historical data, and other unnecessarily codified information. In addition, this document moved most of the general provisions of subpart A of part 1952 into part 1902, where the general regulations on State Plan criteria are found. It also amended several other OSHA regulations to delete references to part 1952, which will no longer apply. A companion proposed rule was also published on that date.

In the direct final rule, OSHA stated that it would publish a **Federal Register** document confirming the effective date of the direct final rule and withdraw the proposed rule if it received no significant adverse comments on the direct final rule or the proposal. OSHA received no comments on the direct final rule or the proposed rule. Accordingly, OSHA is confirming the effective date of the direct final rule and the proposed rule is withdrawn.

Approval of collections of information: The proposed rule and the direct final rule also contained a request for comments on an Information Collection Request under the Paperwork Reduction Act of 1995 (PRA), which covers all collections of information in OSHA State Plan regulations. OMB received no comments. OMB has approved the revised collections of information and is retaining OMB control number 1218–0247 for these requirements. The expiration date for the approval is April 30, 2016.