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[4830-01-p]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[TD 9705]

RIN 1545-BL91

Minimum Essential Coverage and Other Rules Regarding the Shared Responsibility Payment for Individuals

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations relating to the requirement to maintain minimum essential coverage enacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended by the TRICARE Affirmation Act and Public Law 111-173 (collectively, the Affordable Care Act). These final regulations provide individual taxpayers with guidance under section 5000A of the Internal Revenue Code on the requirement to maintain minimum essential coverage and rules governing certain types of exemptions from that requirement.

DATES: Effective Date: These regulations are effective on **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

Applicability Date: For date of applicability, see §1.5000A-5(c).

FOR FURTHER INFORMATION CONTACT: Sue-Jean Kim or John B. Lovelace at (202) 317-7006 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains final regulations that amend the Income Tax Regulations (26 CFR part 1) under section 5000A relating to the individual shared responsibility provision. Section 5000A was enacted by the Affordable Care Act. Section 5000A generally requires individuals to have qualifying health care coverage (called minimum essential coverage), qualify for a health coverage exemption, or make a shared responsibility payment when filing a Federal income tax return. On January 27, 2014, a notice of proposed rulemaking (REG-141036-13) was published in the **Federal Register** (79 FR 4302).

Written comments responding to the notice of proposed rulemaking of January 27, 2014, were received. The comments are available for public inspection at www.regulations.gov or on request. No public hearing was requested or held. After considering all the comments, the proposed regulations are adopted as revised by this Treasury decision. The comments and revisions are discussed in the preamble.

As described in the Summary of Comments and Explanation of Revisions, in related guidance, Notice 2014-76, 2014-50 IRB (available at www.irs.gov) (see §601.601(d)), the Treasury Department and the IRS provide a comprehensive list of the hardship exemptions that may be claimed for 2014 on a Federal income tax return without obtaining a hardship exemption certification from a Health Insurance Marketplace (Marketplace).

Summary of Comments and Explanation of Revisions

I. Minimum Essential Coverage

A. Coverage for the medically needy

The proposed regulations provide that certain categories of Medicaid coverage authorized under Title XIX of the Social Security Act (42 U.S.C. 1396 and following sections) that are not required to be comprehensive are not generally government-sponsored minimum essential coverage under section 5000A(f)(1). Specifically, under the proposed regulations, coverage offered to individuals with high medical expenses who would be eligible for Medicaid but for their income level (medically needy individuals) (see section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. 1936a(a)(10)(C))) generally is not minimum essential coverage. Commenters agreed that Medicaid coverage for medically needy individuals that is not comprehensive should not be minimum essential coverage. The final regulations retain the rule in proposed regulations that Medicaid coverage for medically needy individuals is not government-sponsored minimum essential coverage under section 5000A(f)(1)(A).

The preamble to the proposed regulations explains that although Medicaid coverage offered to medically needy individuals generally is not minimum essential coverage, the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, may in appropriate circumstances designate certain coverage for medically needy individuals as minimum essential coverage pursuant to section 5000A(f)(1)(E). Some commenters suggested that the determination of whether a particular state's program for medically needy individuals is comprehensive, and therefore should be recognized as minimum essential coverage, should be based on whether the program offers the essential health benefits required by the Affordable Care Act for coverage in the individual and group health insurance markets. The determination of whether coverage is designated as minimum essential coverage under

section 5000A(f)(1)(E) is under the jurisdiction of the Department of Health and Human Services (HHS). On November 7, 2014, the HHS provided guidance on the considerations that it intends to apply in recognizing Medicaid coverage for medically needy individuals as minimum essential coverage. HHS Centers for Medicare & Medicaid Services, Minimum Essential Coverage (SHO #14-002) (Nov. 7, 2014) (available at www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf).

B. Section 1115 demonstration projects

The proposed regulations provide that coverage authorized under section 1115(a)(2) of the Social Security Act (42 U.S.C. 1315(a)(2)) is generally not minimum essential coverage. One commenter recommended that the citation be changed to refer to section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)(1)), because demonstration projects authorized under section 1115(a)(1) may limit the benefits available to individuals whose coverage is authorized under the approved state plan and limited-benefit coverage should not be treated as minimum essential coverage.

A section 1115 demonstration project authorized under section 1115(a)(1) of the Social Security Act may provide only limited benefits. Accordingly, the final regulations adopt the commenter's recommendation and provide that coverage authorized under section 1115(a) of the Social Security Act is not government-sponsored minimum essential coverage under section 5000A(f)(1)(A).

The preamble to the proposed regulations explains that certain coverage under a section 1115 demonstration project may be recognized as minimum essential coverage by the Secretary of HHS, in coordination with the Secretary of the Treasury, under section 5000A(f)(1)(E). On November 7, 2014, HHS released guidance on the

considerations it will apply in recognizing a section 1115 demonstration project as minimum essential coverage under section 5000A(f)(1)(E). HHS Centers for Medicare & Medicaid Services, Minimum Essential Coverage (SHO #14-002) (Nov. 7, 2014) (available at www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf).

II. Exemption for Individuals Who Cannot Afford Coverage

A. Employer contributions to a cafeteria plan (flex contributions)

The preamble to the proposed regulations requests comments on the treatment for purposes of section 5000A of employer contributions under a section 125 cafeteria plan to the extent employees may not opt to receive the employer contribution as a taxable benefit. Specifically, the preamble to the proposed regulations requests comments about how these contributions should be taken into account for purposes of determining the affordability of coverage.

As described in this preamble after consideration of the comments received, the final regulations provide that, for purposes of determining the affordability of coverage, the required contribution is reduced by any contributions made by an employer 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 (such contributions are referred to in this preamble as health flex contributions).

One commenter suggested that the value of any benefit provided under a cafeteria plan should be included in the taxpayer's household income for purposes of determining eligibility for the exemption for unaffordable coverage, regardless of whether the benefit is taxable. The commenter noted that taxable benefits are included

in an employee's household income, thereby increasing the likelihood that coverage offered by an employer will be affordable. Reasoning that a nontaxable benefit similarly provides an employee with a financial benefit, the commentator argued that nontaxable contributions should be considered available to purchase minimum essential coverage to eliminate any possible employee incentive under section 5000A for choosing a taxable or nontaxable benefit.

The suggestion to include employer contributions to a cafeteria plan in an employee's household income is inconsistent with the definition of household income in section 5000A(c)(4)(B) and the increase to household income for the purposes of determining affordability provided in section 5000A(e)(1)(A). Household income as defined in section 5000A(c)(4)(B), while specifically including certain amounts otherwise excluded from gross income such as tax-exempt interest, does not include amounts excluded from gross income under section 125. Section 5000A(e)(1)(A) provides that, for purposes of determining the affordability of coverage, household income is increased by any portion of the required contribution paid through a salary reduction arrangement. Health flex contributions that can be received under a cafeteria plan, however, are not made pursuant to a salary reduction arrangement. Section 5000A does not direct that household income include all amounts excluded from gross income pursuant to a cafeteria plan. Accordingly, the final regulations do not incorporate the suggestion to include all benefits provided under a cafeteria plan in the taxpayer's household income.

Another commenter recommended that contributions under a cafeteria plan should be taken into account in determining the employee's required contribution if the

contributions could be used to purchase minimum essential coverage, regardless of whether the contributions could be used to purchase other benefits. The commenter suggested that a contrary rule could potentially cause employers to limit employee choice by structuring cafeteria plans so that contributions can be used only to pay for minimum essential coverage.

Section 5000A(e)(1)(B) defines an employee's required contribution by reference to the portion of the annual premium that would be paid by the employee if the employee purchased coverage. The statute does not require an employee to treat amounts provided pursuant to a cafeteria plan as reductions to the employee's required contribution. If an employee may use nontaxable employer contributions to a cafeteria plan to pay for minimum essential coverage and only to pay for medical expenses, then that represents a real reduction in the cost to the employee of purchasing minimum essential coverage. In such a case, it is appropriate to treat the amounts as a reduction in the employee's required contribution. However, if an employee's use of nontaxable employer contributions to a cafeteria plan is not limited to medical expenses, then it cannot be assumed that the employee will use the contribution for purchasing minimum essential coverage.

Accordingly, the final regulations provide that health flex contributions made available for the current plan year are taken into account for purposes of determining an individual's required contribution. As a result, health flex contributions reduce an employee's, or related individual's, required contribution for employer-sponsored coverage.

B. Health reimbursement arrangements

The proposed regulations provide that amounts newly made available in the current plan year under a health reimbursement arrangement (HRA) that is integrated with an eligible employer-sponsored plan are taken into account in determining the employee's or related individual's required contribution if an employee may use them to pay the employee's share of premiums for coverage under the plan. No comments were received on this proposed rule. However, this preamble addresses comments received in response to an identical rule provided in proposed regulations under section 36B (REG-125398-12, 78 FR 25909) (section 36B proposed regulations) published on May 3, 2013.

Commenters requested guidance on the requirements for an HRA to be integrated with eligible employer-sponsored coverage. Notice 2013-54 (2013-40 IRB 287) (see §601.601(d)), and for this purpose identical guidance issued by the Department of Labor and with which HHS concurred provides, however, that an HRA is integrated with another group health plan only if, among other things, an employee enrolls in the other group health plan. Because an employee who enrolls in eligible employer-sponsored coverage is not eligible for the premium tax credit subsidy, whether or not the eligible employer-sponsored coverage is affordable, requiring an HRA to be integrated with a primary group health plan for purposes of determining affordability would be meaningless. Therefore, the final regulations cross-reference Notice 2013-54 and clarify that amounts newly made available under an HRA count toward an employee's required contribution if the HRA would have been integrated with an eligible employer-sponsored plan if the employee had enrolled in the primary plan.

Notice 2013-54 also provides that under certain circumstances an HRA offered by an employer may be integrated with a group health plan offered by a different employer, for example a plan offered by the employer of an employee's spouse. Notice 2013-54 indicated, however, that an HRA could not be integrated with a plan offered by another employer for purposes of determining affordability and minimum value under section 36B. Accordingly, the final regulations provide that, for purposes of determining an individual's required contribution, an HRA is taken into account only if the HRA and the primary eligible employer-sponsored coverage are offered by the same employer.

Commenters suggested that HRAs should be considered integrated with any plan that provides minimum essential coverage, whether that plan is an employer plan or a plan purchased through a Marketplace. As explained in Notice 2013-54, the combination of an HRA and a plan purchased through a Marketplace may raise significant issues under the market reforms applicable to the group insurance market. For this reason, as well as to reduce complexity through consistent rules, the Treasury Department and the IRS have concluded that the rules for determining when an HRA is considered integrated with another group health plan for purposes of section 5000A should be consistent with the rules applicable for purposes of application of the market reforms, and the final regulations, therefore, cross-reference Notice 2013-54. The rules addressed in Notice 2013-54 are under the jurisdiction of the Departments of Labor and HHS as well as the Treasury Department and the IRS and are, therefore, outside the scope of these regulations.

Under the section 36B proposed regulations, HRA amounts that may be used to pay premiums or to pay both premiums and cost-sharing are counted toward

affordability. A commenter suggested that HRA amounts should not count toward affordability unless the amounts may be used only for premiums. The commenter observed that counting HRA amounts that may be used either for premiums or cost-sharing in determining affordability could lead to double counting for affordability and minimum value purposes under section 36B.

The final regulations clarify that, in general, HRA contributions count toward 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. Under the section 36B proposed regulations, HRA amounts that may be used only for cost-sharing are counted for purposes of minimum value and not for affordability. Accordingly, HRA contributions that can be used only to pay for cost-sharing do not count toward affordability. The Treasury Department and the IRS anticipate that the section 36B proposed regulations addressing HRA contributions and minimum value will be adopted in section 36B final regulations and, thus, HRA contributions that can be used for premiums and cost-sharing will only count for affordability and there will be no double counting of these contributions.

Commenters suggested that employers should be permitted to treat HRA contributions as made in particular months during a year, which could affect their potential liability under the employer shared responsibility requirement of section 4980H. Employees who enroll in eligible employer-sponsored coverage may not claim the premium tax credit for their coverage in a qualified health plan and must be able to determine the amount of their annual required contribution before deciding whether to

enroll in eligible employer-sponsored coverage. Accordingly, the final regulations clarify that employer contributions to an HRA count towards an employee's required contribution 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. The Treasury Department and the IRS anticipate adopting the same rule when the section 36B proposed regulations are finalized.

A commenter argued that health insurance issuers should not be required to determine if employers are making contributions to an HRA or HSA or otherwise determine limitations employers place on the use of funds in an HRA or HSA. Neither the proposed regulations under sections 36B or 5000A nor the final regulations impose these requirements on health insurance issuers.

A commenter stated that stand-alone HRAs for pre-Medicare eligible retirees should not be considered minimum essential coverage under certain circumstances. The final regulations do not address this issue, which is outside the scope of the regulations.

C. Wellness program incentives

The proposed regulations provide that, in determining whether coverage under an eligible employer-sponsored plan is affordable for purposes of the affordability exemption in section 5000A(e)(1), nondiscriminatory wellness program incentives are treated as earned only if the incentives relate to tobacco use. For this purpose, a nondiscriminatory wellness program is a wellness program that does not violate the wellness plan regulations whether the program is participatory or outcome based. See

§54.9802-1(f), 29 CFR 2590.702(f), and 45 CFR 146.121(f) for regulations governing wellness program incentives issued by the Departments of Labor and HHS, and the Treasury Department and the IRS (tri-agency regulations). The section 36B proposed regulations include an identical rule for counting wellness program incentives in determining an individual's required contribution. Comments were received on both the rule in the proposed regulations and the identical rule in the section 36B proposed regulations. Both sets of comments were considered in the development of these final regulations.

The proposed regulations provide that the affordability of eligible employer-sponsored coverage is 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 of coverage that requires a higher initial premium for tobacco users is determined based on the premium that is charged to non-tobacco users or to tobacco users who complete the related wellness program, such as attending smoking cessation classes.

Some commenters requested that all wellness incentives, including those related to tobacco use, be treated as unearned when determining the affordability and minimum value of an offer of eligible employer-sponsored coverage. These commenters asserted that wellness incentives could be used to discriminate based on health status or that certain individuals would be unable to complete the wellness program and earn the wellness incentives.

Other commenters requested that all wellness incentives, including those related to tobacco use, be treated as earned when determining the affordability and minimum

value of an offer of eligible employer-sponsored coverage. These commenters asserted that wellness incentives are an effective way of encouraging healthy lifestyle adjustments and reducing health costs and that the consumer protections in the tri-agency regulations that were finalized on June 3, 2013 (TD 9620, 78 FR 33158), ensure that wellness incentives will not be used to discriminate based on health status or burdens to employees. Some of these commenters advised, however, that if the final regulations do not treat all wellness incentives as unearned, they favor the proposed rule as a reasonable alternative.

After consideration of these comments, the 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. These rules are consistent with policies related to tobacco use reflected in the Affordable Care Act, such as allowing issuers to charge higher premiums based on tobacco use. The Treasury Department and the IRS anticipate adopting the same rules when the section 36B proposed regulations are finalized.

Commenters requested guidance on whether a wellness incentive is treated as earned or unearned when an employee must complete a wellness program related to tobacco use and a program unrelated to tobacco use to receive an incentive. The final regulations clarify that a wellness incentive that includes any component unrelated to tobacco use is treated as unearned. If, however, 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.

A commenter requested clarification that programs that provide a discount or rebate and programs that impose a surcharge both provide wellness program incentives under the final regulations. Another commenter asked that the final regulations clarify that nondiscriminatory wellness programs include both participatory and health-contingent wellness programs. The final regulations clarify that the term wellness program incentives has the same meaning as the term reward in the tri-agency regulations. Thus, programs that provide a discount or rebate, programs that impose a surcharge, and participatory and health-contingent wellness programs are wellness program incentives under the final regulations.

III. Hardship Exemptions

Under section 5000A(e)(5), an individual is exempt from section 5000A if the individual has an exemption certification issued by the Marketplace stating that HHS has determined that the individual suffered a hardship with respect to the ability to obtain minimum essential coverage. The proposed regulations provide that, under certain circumstances, a taxpayer may claim a hardship exemption on a Federal income tax return without first obtaining a hardship exemption certification from a Marketplace. Specifically, the proposed regulations provide that an individual may claim a hardship exemption on the Federal income tax return if they are specifically described in 45 CFR 155.605(g)(3) (relating to individuals with gross income below the filing threshold) or 45 CFR 155.605(g)(5) (relating to employed and related individuals whose combined cost of employer-sponsored coverage exceeds the required contribution percentage), or if the individual is described HHS guidance released on October 28, 2013 (relating to

individuals who enrolled in a plan through a Marketplace before the close of the open enrollment period in 2014 but had a gap in coverage before the coverage was effective).

Finally, the proposed regulations provide that a taxpayer may claim a hardship exemption on a Federal income tax return in any situation that is (1) described in published guidance issued by HHS permitting an individual to claim the exemption on a Federal income tax return, and (2) described in published guidance issued by the IRS that allows an individual to claim the exemption on a Federal income tax return without obtaining a hardship exemption certification.

Commenters requested that taxpayers be allowed to claim other hardship exemptions without obtaining hardship exemption certifications. Specifically, commenters requested that taxpayers eligible for the hardship exemption described in 45 CFR 155.605(g)(6), for an Indian eligible for services through Indian Health Service (IHS) or through an Indian health care provider, be allowed to claim the exemption without obtaining a hardship exemption certification from a Marketplace. HHS issued guidance on September 18, 2014, that addresses this comment. In particular, the HHS guidance identified the hardship situation described in 45 CFR 155.605(g)(6) and indicated that an exemption for that hardship may be claimed on a Federal income tax return pursuant to guidance issued by the Treasury Department and the IRS. See HHS Centers for Medicare & Medicaid Services, Shared Responsibility Guidance--Exemption for Individuals Eligible for Services through an Indian Health Care Provider (Sept. 18, 2014) (available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/guidance-exemption-certain-AIAN.pdf>).

Commenters also requested that a taxpayer be allowed to claim a hardship exemption without obtaining a hardship exemption certification if he or she is eligible for the hardship exemption described in 45 CFR 155.605(g)(4), which applies to an individual who is determined ineligible for Medicaid for one or more months during a benefit year solely because the individual resides in a state that has not expanded Medicaid under section 2001(a) of the Affordable Care Act. HHS issued guidance on November 21, 2014, addressing this comment. In particular, the HHS guidance provides that an individual is eligible for a hardship exemption for the taxable year if at any time during 2014 the individual resided in a state that did not expand Medicaid coverage and the individual's household income, within the meaning of section 36B, is below 138 percent of the applicable federal poverty level for the individual's family size. See HHS Centers for Medicare & Medicaid Services, Guidance on Hardship Exemptions for Persons Meeting Certain Criteria (Nov. 21, 2014) (available at www.cms.gov).

To consolidate the list of circumstances described in the proposed regulations with any additional circumstances that have been or will be identified, §1.5000A-3(h)(3)(i) of the final regulations removes the references to specific hardship circumstances and instead provides that a taxpayer may claim a hardship exemption on a Federal income tax return without obtaining an exemption certification for any month that includes a day on which the taxpayer satisfies the requirements of a hardship for which HHS, and the Treasury Department and the IRS, issue published guidance. Notice 2014-76, 2014-50 IRB (available at www.irs.gov) (see §601.601(d)), released concurrently with these regulations, provides a comprehensive list of all hardship

exemptions that may be claimed on a Federal income tax return without obtaining a hardship exemption certification. The list of hardship exemptions that may be claimed on a Federal income tax return without obtaining a hardship exemption certification includes the following: (a) the hardship exemptions described in 45 CFR 155.605(g)(3) and (g)(5); (b) the hardship exemption described in HHS guidance issued October 28, 2013, relating to individuals enrolled in Marketplace coverage on or before March 31, 2014; (c) the hardship exemption described in HHS guidance released on March 26, 2014, relating to individuals “in line” to enroll in coverage through the Marketplace on March 31, 2013; (d) the hardship exemption described in HHS guidance released on March 31, 2014, relating to individuals who applied for CHIP during the 2014 open enrollment period and were found eligible; (e) the hardship exemption described in HHS guidance released on May 2, 2014, relating to individuals who enrolled outside the Marketplace in minimum essential coverage that is effective on or before May 1, 2014; (f) the hardship exemption described in HHS guidance issued September 18, 2014, relating to individuals eligible for services through an Indian health care provider; and (g) the hardship exemption described in HHS guidance issued November 21, 2014, relating to individuals with specified household incomes who reside in a state that did not expand Medicaid.

Commenters requested that the IRS, in conjunction with HHS, adopt additional hardship exemptions to address specific situations. Other commenters requested that the transition relief provided in Notice 2014-10, 2014-9 IRB 605, for individuals enrolled in limited benefit Medicaid programs that are not minimum essential coverage be

extended to 2015. Some commenters specifically requested that no additional transition relief be provided.

Authority to define circumstances giving rise to a hardship exemption, as well as authority to grant hardship exemptions in individual cases, resides with HHS. In guidance released on November 7, 2014, HHS described additional circumstances that Marketplaces may use when determining what constitutes a hardship effective January 1, 2015. HHS Centers for Medicare & Medicaid Services, Minimum Essential Coverage (SHO #14-002) (Nov. 7, 2014) (available at www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf). The additional circumstances include enrollment in Medicaid coverage for pregnant women and for medically needy individuals that is not minimum essential coverage. HHS provides additional guidance on the hardship exemption in regulations. See Patient Protection and Affordable Care Act: Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions, 78 FR 39494 (codified at 45 CFR part 155).

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory 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), 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, and no comments were received.

Drafting Information

The principal authors of these final regulations are Sue-Jean Kim and John B. Lovelace of the Office of Associate Chief Counsel (Income Tax and Accounting). Other personnel from the Treasury Department and the IRS 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. An undesignated center heading is added immediately following §1.1563-4 to read as follows:

Individual Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage

Par. 3. Section 1.5000A-0 is amended by:

1. Revising the entry for §1.5000A-2(b)(2).
2. Removing the entries for §1.5000A-2(b)(2)(i), (b)(2)(ii), and (b)(2)(iii).
3. Revising the entries for §1.5000A-3(e)(4)(ii)(C) and (e)(4)(ii)(D).
4. Adding a new entry for §1.5000A-3(e)(4)(ii)(E).
5. Revising the entry for §1.5000A-3(h)(3).

The revisions and addition read as follows.

§1.5000A-0 Table of contents.

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§1.5000A-2 Minimum essential coverage.

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(b) * * *

(2) Certain health care coverage not minimum essential coverage under a government-sponsored program.

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§1.5000A-3 Exempt individuals.

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(e) * * *

(4) * * *

(ii) * * *

(C) Wellness program incentives.

(D) Credit allowable under section 36B.

(E) Required contribution for part-year period.

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(h) * * *

(3) Hardship exemption without hardship exemption certification.

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Par. 4. Section 1.5000A-2 is amended by:

1. Revising paragraphs (b)(1)(ii) and (b)(2).

2. Removing the language "health insurance" in paragraph (g).

The revisions read as follows:

§1.5000A-2 Minimum essential coverage.

* * * * *

(b) * * *

(1) * * *

(ii) Medicaid. The Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1396 and following sections);

* * * * *

(2) Certain health care coverage not minimum essential coverage under a government-sponsored program. Government-sponsored program does not mean any of the following:

(i) Optional coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XXI));

(ii) Optional coverage of tuberculosis-related services under section 1902(a)(10)(A)(ii)(XII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XII));

(iii) Coverage of pregnancy-related services under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX));

(iv) Coverage limited to treatment of emergency medical conditions in accordance with 8 U.S.C. 1611(b)(1)(A), as authorized by section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v));

(v) Coverage for medically needy individuals under section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)) and 42 CFR 435.300 and following sections;

(vi) Coverage authorized under section 1115(a) of the Social Security Act (42 U.S.C. 1315(a));

(vii) Coverage under section 1079(a), 1086(c)(1), or 1086(d)(1) of title 10, U.S.C., that is solely limited to space available care in a facility of the uniformed services for individuals excluded from TRICARE coverage for care from private sector providers; and

(viii) Coverage under sections 1074a and 1074b of title 10, U.S.C., for an injury, illness, or disease incurred or aggravated in the line of duty for individuals who are not on active duty.

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Par. 5. Section 1.5000A-3 is amended by:

1. Revising paragraph (e)(3)(ii)(D).
2. Redesignating paragraph (e)(3)(ii)(E) as (e)(3)(ii)(F), revising newly redesignated paragraph (e)(3)(ii)(F), and adding a new paragraph (e)(3)(ii)(E).
3. Redesignating paragraphs (e)(4)(ii)(C) and (e)(4)(ii)(D) as (e)(4)(ii)(D) and (e)(4)(ii)(E), respectively, and adding and reserving a new paragraph (e)(4)(ii)(C).
4. Revising paragraphs (h)(1) and (h)(3).

The revisions and additions read as follows:

§1.5000A-3 Exempt individuals.

* * * * *

(e) * * *

(3) * * *

(ii) * * *

(D) 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, are counted toward 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) or in any successor published guidance (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 count toward 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.

(E) Employer contributions to cafeteria plans. Amounts made available for the current plan year under a cafeteria plan, within the meaning of section 125, are taken into account in determining an employee's or a related individual's required contribution if:

(1) The employee may not opt to receive the amount as a taxable benefit;

(2) The employee may use the amount to pay for minimum essential coverage; and

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

(F) Wellness program incentives. Nondiscriminatory wellness program incentives, within the meaning of §54.9802-1(f) of this chapter, 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.

* * * * *

(4) * * *

(ii) * * *

(C) Wellness programs incentives. [Reserved]

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(h) Individuals with hardship exemption certification—(1) In general. Except as provided in paragraph (h)(3) of this section, an individual is an exempt individual for a month that includes a day on which the individual has in effect a hardship exemption certification described in paragraph (h)(2) of this section.

* * * * *

(3) Hardship exemption without hardship exemption certification. An individual may claim an exemption without obtaining a hardship exemption certification described in paragraph (h)(2) of this section for any month that includes a day on which the individual meets the requirements of any hardship for which:

(i) The Secretary of HHS issues guidance of general applicability describing the hardship and indicating that an exemption for such hardship can be claimed on a Federal income tax return pursuant to guidance published by the Secretary; and

(ii) The Secretary issues published guidance of general applicability, see §601.601(d)(2) of this chapter, allowing an individual to claim the hardship exemption on a return without obtaining a hardship exemption from an Exchange.

* * * * *

Par. 6. Section 1.5000A-4 is amended by revising paragraph (a) introductory text and paragraph (a)(1) to read as follows:

§1.5000A-4 Computation of shared responsibility payment.

(a) In general. For each taxable year, the shared responsibility payment imposed on a taxpayer in accordance with §1.5000A-1(c) is the lesser of--

(1) The sum of the monthly penalty amounts; or

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John Dalrymple
Deputy Commissioner for Services and Enforcement.

Approved: November 20, 2014

Mark J. Mazur
Assistant Secretary of the Treasury (Tax Policy).

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