

Paperwork Reduction Act

As there is no collection of information proposed in this document, the provisions of the Paperwork Reduction Act (44 U.S.C. 3507) are inapplicable.

Signing Authority

This document is being issued in accordance with § 0.1(a)(1) of the CBP Regulations (19 CFR 0.1(a)(1)) pertaining to the authority of the Secretary of the Treasury (or his/her delegate) to approve regulations related to certain customs revenue functions.

List of Subjects in 19 CFR Part 102

Canada, Customs duties and inspections, Imports, Mexico, Reporting and recordkeeping requirements, Trade agreements.

Proposed Amendments to the CBP Regulations

For the reasons set forth above, part 102 of title 19 of the Code of Federal Regulations (19 CFR part 102) is proposed to be amended as set forth below.

PART 102—RULES OF ORIGIN

■ 1. The authority citation for part 102, CBP regulations, continues to read as follows:

Authority: 19 U.S.C. 66, 1202 (General Note 3(i), Harmonized Tariff Schedule of the United States (HTSUS)), 1624, 3314, 3592.

§ 102.19 [Amended]

■ 2. In § 102.19:

■ a. Paragraph (a) is amended by adding the words “or (c)” after the words “paragraph (b)”; and

■ b. Paragraph (c) is added to read as follows:

(c) If a good classifiable under heading 0907, 0908, 0909, or subheading 0910.11, 0910.12, 0910.30, 0910.99 or 1207.91, HTSUS, is originating within the meaning of section 181.1(q) of this chapter, but is not determined under section 102.11(a) or (b) to be a good of a single NAFTA country, the country of origin of such good is the last NAFTA country in which that good underwent production, provided that a Certificate of Origin (see § 181.11 of this Chapter) has been completed and signed for the good.

R. Gil Kerlikowske,

Commissioner, U.S. Customs and Border Protection.

Approved: July 1, 2016.

Timothy E. Skud,

Deputy Assistant Secretary of the Treasury.

[FR Doc. 2016-16088 Filed 7-7-16; 8:45 am]

BILLING CODE P

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Parts 1 and 301**

[REG-109086-15]

RIN 1545-BN50

Premium Tax Credit NPRM VI

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to the health insurance premium tax credit (premium tax credit) and the individual shared responsibility provision. These proposed regulations affect individuals who enroll in qualified health plans through Health Insurance Exchanges (Exchanges, also called Marketplaces) and claim the premium tax credit, and Exchanges that make qualified health plans available to individuals and employers. These proposed regulations also affect individuals who are eligible for employer-sponsored health coverage and individuals who seek to claim an exemption from the individual shared responsibility provision because of unaffordable coverage. Although employers are not directly affected by rules governing the premium tax credit, these proposed regulations may indirectly affect employers through the employer shared responsibility provisions and the related information reporting provisions.

DATES: Written (including electronic) comments and requests for a public hearing must be received by September 6, 2016.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG-109086-15), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG-109086-15), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW., Washington, DC, or sent electronically via the Federal eRulemaking Portal at <http://www.regulations.gov> (REG-109086-15).

FOR FURTHER INFORMATION CONTACT:

Concerning the proposed regulations, Shareen Pflanz, (202) 317-4727; concerning the submission of comments and/or requests for a public hearing, Oluwafunmilayo Taylor, (202) 317-6901 (not toll-free calls).

SUPPLEMENTARY INFORMATION:**Paperwork Reduction Act**

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by September 6, 2016. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the IRS, including whether the information will have practical utility;

How the quality, utility, and clarity of the information to be collected may be enhanced;

How the burden of complying with the proposed collection of information may be minimized, including through the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

The collection of information in these proposed regulations is in § 1.36B-5. The collection of information is necessary to reconcile advance payments of the premium tax credit and determine the allowable premium tax credit. The collection of information is required to comply with the provisions of section 36B of the Internal Revenue Code (Code). The likely respondents are Marketplaces that enroll individuals in qualified health plans.

The burden for the collection of information contained in these proposed regulations will be reflected in the burden on Form 1095-A, *Health Insurance Marketplace Statement*, which is the form that will request the information from the Marketplaces in the proposed regulations.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Background

Beginning in 2014, under 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), eligible individuals who purchase coverage under a qualified health plan through an Exchange may claim a premium tax credit under section 36B of the Code. Section 36B was subsequently amended by the Medicare and Medicaid Extenders Act of 2010, Public Law 111–309 (124 Stat. 3285 (2010)); the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Public Law 112–9 (125 Stat. 36 (2011)); and the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112–10 (125 Stat. 38 (2011)).

The Affordable Care Act also added section 5000A to the Code. Section 5000A was subsequently amended by the TRICARE Affirmation Act of 2010, Public Law 111–159 (124 Stat. 1123 (2010)) and Public Law 111–173 (124 Stat. 1215 (2010)). Section 5000A provides that, for months beginning after December 31, 2013, a nonexempt individual must have qualifying health care coverage (called minimum essential coverage) or make an individual shared responsibility payment.

Applicable Taxpayers

To be eligible for a premium tax credit, an individual must be an applicable taxpayer. Among other requirements, under section 36B(c)(1) an applicable taxpayer is a taxpayer whose household income for the taxable year is between 100 percent and 400 percent of the Federal poverty line (FPL) for the taxpayer's family size (or is a lawfully present non-citizen who has income below 100 percent of the FPL and is ineligible for Medicaid). A taxpayer's family size is equal to the number of individuals in the taxpayer's family. Under section 36B(d)(1), a taxpayer's family consists of the individuals for whom the taxpayer claims a personal exemption deduction under section 151 for the taxable year. Taxpayers may claim a personal exemption deduction for themselves, a spouse, and each of their dependents.

Under section 1412 of the Affordable Care Act, advance payments of the premium tax credit (advance credit payments) may be made directly to insurers on behalf of eligible individuals. The amount of advance credit payments made on behalf of a taxpayer in a taxable year is determined by a number of factors including projections of the taxpayer's household

income and family size for the taxable year. Taxpayers who receive the benefit of advance credit payments are required to file an income tax return to reconcile the amount of advance credit payments made during the year with the amount of the credit allowable for the taxable year.

Under § 1.36B–2(b)(6), in general, a taxpayer whose household income for a taxable year is less than 100 percent of the applicable FPL is nonetheless treated as an applicable taxpayer if (1) the taxpayer or a family member enrolls in a qualified health plan, (2) an Exchange estimates at the time of enrollment that the taxpayer's household income for the taxable year will be between 100 and 400 percent of the applicable FPL, (3) advance credit payments are authorized and paid for one or more months during the taxable year, and (4) the taxpayer would be an applicable taxpayer but for the fact that the taxpayer's household income for the taxable year is below 100 percent of the applicable FPL.

Premium Assistance Credit Amount

Under section 36B(a), a taxpayer's premium tax credit is equal to the premium assistance credit amount for the taxable year. Section 36B(b)(1) and § 1.36B–3(d) generally provide that the premium assistance credit amount is the sum of the premium assistance amounts for all coverage months in the taxable year for individuals in the taxpayer's family. The premium assistance amount for a coverage month is the lesser of (1) the premiums for the month for one or more qualified health plans that cover a taxpayer or family member (enrollment premium), or (2) the excess of the adjusted monthly premium for the second lowest cost silver plan (as described in section 1302(d)(1)(B) of the Affordable Care Act (42 U.S.C. 18022(d)(1)(B)) offered through the Exchange for the rating area where the taxpayer resides that would provide coverage to the taxpayer's coverage family (the benchmark plan), over 1/12 of the product of the taxpayer's household income and the applicable percentage for the taxable year (the contribution amount). In general, the benchmark plan's adjusted monthly premium is the premium an insurer would charge for the plan adjusted only for the ages of the covered individuals. The applicable percentage is provided in a table that is updated annually and represents the portion of a taxpayer's household income that the taxpayer is expected to pay if the taxpayer's coverage family enrolls in the benchmark plan. See, for example, Rev. Proc. 2014–62, 2014–2 C.B. 948

(providing the applicable percentage table for taxable years beginning in 2016) and Rev. Proc. 2014–37, 2014–2 C.B. 363 (providing the applicable percentage table for taxable years beginning in 2015). A taxpayer's coverage family refers to all members of the taxpayer's family who enroll in a qualified health plan in a month and are not eligible for minimum essential coverage as defined in section 5000A(f) (other than coverage in the individual market) for that month.

Under section 1301(a)(1)(B) of the Affordable Care Act, a qualified health plan must offer the essential health benefits package described in section 1302(a). Under section 1302(b)(1)(J) of the Affordable Care Act, the essential health benefits package includes pediatric services, including oral and vision care. Section 1302(b)(4)(F) of the Affordable Care Act provides that, if an Exchange offers a plan described in section 1311(d)(2)(B)(ii)(I) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)(I)) (a stand-alone dental plan), other health plans offered through the Exchange will not fail to be qualified health plans solely because the plans do not offer pediatric dental benefits.

For purposes of calculating the premium assistance amount for a taxpayer who enrolls in both a qualified health plan and a stand-alone dental plan, section 36B(b)(3)(E) provides that the enrollment premium includes the portion of the premium for the stand-alone dental plan properly allocable to pediatric dental benefits that are included in the essential health benefits required to be provided by a qualified health plan.

Section 36B(b)(3)(B) provides that the benchmark plan with respect to an applicable taxpayer is the second lowest cost silver plan offered by the Marketplace through which the applicable taxpayer (or a family member) enrolled and which provides (1) self-only coverage, in the case of unmarried individuals (other than a surviving spouse or head of household) who do not claim any dependents, or any other individual who enrolls in self-only coverage, and (2) family coverage, in the case of any other applicable taxpayer. Section 1.36B–1(l) provides that self-only coverage means health insurance that covers one individual. Section 1.36B–1(m) provides that family coverage means health insurance that covers more than one individual.

Under § 1.36B–3(f)(3), if there are one or more silver-level plans offered through the Exchange for the rating area where the taxpayer resides that do not cover all members of a taxpayer's

coverage family under one policy (for example, because of the relationships within the family), the benchmark plan premium is the second lowest-cost option for covering all members of the taxpayer's family, which may be either a single silver-level policy or more than one silver-level policy.

Section 1.36B-3(d)(2) provides that, 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 the enrollment premiums for the month (reduced by any amounts that were refunded) or the excess of the benchmark plan premium for a full month of coverage over the full contribution amount for the month.

Coverage Month

Under section 36B(c)(2)(A) and § 1.36B-3(c)(1), a coverage month is generally any month for which the taxpayer or a family member is covered by a qualified health plan enrolled in through an Exchange on the first day of the month and the premium is paid by the taxpayer or through an advance credit payment. However, section 36B(c)(2) provides that a month is not a coverage month for an individual who is eligible for minimum essential coverage other than coverage in the individual market. Under section 36B(c)(2)(B)(ii), minimum essential coverage is defined by reference to section 5000A(f). Minimum essential coverage includes government-sponsored programs such as most Medicaid coverage, Medicare part A, the Children's Health Insurance Program (CHIP), most TRICARE programs, most coverage provided to veterans under title 38 of the United States Code, and the Nonappropriated Fund Health Benefits Program of the Department of Defense. See section 5000A(f)(1) and § 1.5000A-2(b). Section 1.36B-2(c)(3)(i) provides that, for purposes of section 36B, the government-sponsored programs described in section 5000A(f)(1)(A) are not considered eligible employer-sponsored plans.

Under § 1.36B-2(c)(2)(i), an individual generally is treated as eligible for government-sponsored minimum essential coverage as of the first day of the first full month that the individual meets the criteria for coverage and is eligible to receive benefits under the government program. However, under § 1.36B-2(c)(2)(v) an individual is treated as not eligible for Medicaid, CHIP, or a similar program

for a period of coverage under a qualified health plan if, when the individual enrolls in the qualified health plan, an Exchange determines or considers (within the meaning of 45 CFR 155.302(b)) the individual to be ineligible for such program. In addition, § 1.36B-2(c)(2)(iv) provides that if an individual receiving the benefit of advance credit payments is determined to be eligible for a government-sponsored program, and that eligibility is effective retroactively, then, for purposes of the premium tax credit, the individual is treated as eligible for the program no earlier than the first day of the first calendar month beginning after the approval.

Coverage under an eligible employer-sponsored plan is minimum essential coverage. In general, an eligible employer-sponsored plan is coverage provided by an employer to its employees (and their dependents) under a group health plan maintained by the employer. See section 5000A(f)(2) and § 1.5000A-2(c). Under section 5000A(f)(3) and § 1.5000A-2(g), minimum essential coverage does not include any coverage that consists solely of excepted benefits described in section 2791(c)(1), (c)(2), (c)(3), or (c)(4) of the Public Health Service Act (PHS Act) (42 U.S.C. 300gg-91(c)), or regulations issued under those provisions (45 CFR 148.220). In general, excepted benefits are benefits that are limited in scope or are conditional.

Under section 36B(c)(2)(C) and § 1.36B-2(c)(3)(i), except as provided in the next paragraph of this preamble, an individual is treated as eligible for coverage under an eligible employer-sponsored plan only if the employee's share of the premium is affordable and the coverage provides minimum value. Under section 36B(c)(2)(C), an eligible employer-sponsored plan is treated as affordable for an employee if the amount of the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) for self-only coverage does not exceed a specified percentage of the employee's household income. The affordability of coverage for individuals related to an employee is determined in the same manner. Thus, under section 36B(c)(2)(C)(i) and § 1.36B-2(c)(3)(v)(A)(2), an eligible employer-sponsored plan is treated as affordable for an individual eligible for the plan because of a relationship to an employee if the amount of the employee's required contribution for self-only coverage does not exceed a specified percentage of the employee's household income.

Under § 1.36B-2(c)(3)(v)(A)(3), an eligible employer-sponsored plan is not

considered affordable if, when an individual enrolls in a qualified health plan, the Marketplace determines that the eligible employer-sponsored plan is not affordable. However, that rule does not apply for an individual who, with reckless disregard for the facts, provides incorrect information to a Marketplace concerning the employee's portion of the annual premium for coverage under the eligible employer-sponsored plan. In addition, under section 36B(c)(2)(C)(iii) and § 1.36B-2(c)(3)(vii)(A), an individual is treated as eligible for employer-sponsored coverage if the individual actually enrolls in an eligible employer-sponsored plan, even if the coverage is not affordable or does not provide minimum value.

Section 1.36B-2(c)(3)(iii)(A) provides that, subject to the rules described above, an employee or related individual may be considered eligible for coverage under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period. Under § 1.36B-2(c)(3)(ii), plan year means an eligible employer-sponsored plan's regular 12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).

Although coverage in the individual market is minimum essential coverage under section 5000A(f)(1)(C), under section 36B(c)(2)(B)(i), an individual who is eligible for or enrolled in coverage in the individual market (whether or not obtained through the Marketplace) nevertheless may have a coverage month for purposes of the premium tax credit.

Required Contribution for Employer-Sponsored Coverage

Under section 36B(c)(2)(C) and § 1.36B-2(c)(3)(v)(A)(1) and (2), an eligible employer-sponsored plan is treated as affordable for an employee or a related individual if the amount the employee must pay for self-only coverage whether by salary reduction or otherwise (the employee's required contribution) does not exceed a specified percentage of the employee's household income. Under section 36B(c)(2)(C)(i)(II), an employee's required contribution has the same meaning for purposes of the premium tax credit as in section 5000A(e)(1)(B).

Section 5000A provides that, for each month, taxpayers must have minimum essential coverage, qualify for a health coverage exemption, or make an individual shared responsibility

payment when they file a Federal income tax return. Section 5000A(e)(1) and § 1.5000A-3(e)(1) provide that an individual is exempt for a month when the individual cannot afford minimum essential coverage. For this purpose, an individual cannot afford coverage if the individual's required contribution (determined on an annual basis) for minimum essential coverage exceeds a specified percentage of the individual's household income. Under section 5000A(e)(1)(B)(i) and § 1.5000A-3(e)(3)(ii)(A), for employees eligible for coverage under an eligible employer-sponsored plan, the employee's required contribution is the amount an employee would have to pay for self-only coverage (whether paid through salary reduction or otherwise) under the plan. For individuals eligible to enroll in employer-sponsored coverage because of a relationship to an employee (related individual), under section 5000A(e)(1)(C) and § 1.5000A-3(e)(3)(ii)(B), the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all related individuals who are included in the employee's family and are not otherwise exempt under § 1.5000A-3.

Notice 2015-87, 2015-52 I.R.B. 889, provides guidance on determining the affordability of an employer's offer of eligible employer-sponsored coverage for purposes of sections 36B, 5000A, and 4980H (and the related information reporting under section 6056).¹ In relevant part, Notice 2015-87 addresses how to determine the affordability of an employer's offer of eligible employer-sponsored coverage if an employer also makes available an opt-out payment, which is a payment that (1) is available

¹ An assessable payment under section 4980H(b) may arise if at least one full-time employee (as defined in § 54.4980H-1(a)(21)) of the applicable large employer (as defined in § 54.4980H-1(a)(4)) receives the premium tax credit. A full-time employee generally is ineligible for the premium tax credit if the employee is offered minimum essential coverage under an eligible employer-sponsored plan that is affordable and provides minimum value. The determination of whether an applicable large employer has made an offer of affordable coverage under an eligible employer-sponsored plan for purposes of section 4980H(b) generally is based on the standard set forth in section 36B, which provides that an offer is affordable if the employee's required contribution is at or below 9.5 percent (as indexed) of the employee's household income. However, because an employer generally will not know the taxpayer employee's household income, § 54.4980H-5(e)(2) sets forth three safe harbors under which an employer may determine affordability (solely for purposes of section 4980H) based on information that is readily available to the employer (that is, Form W-2 wages, the rate of pay, or the Federal poverty line).

only if the employee declines coverage (which includes waiving coverage in which the employee would otherwise be enrolled) under the employer-sponsored plan, and (2) cannot be used to pay for coverage under the employer-sponsored plan. The arrangement under which the opt-out payment is made available is an opt-out arrangement.

As Notice 2015-87 explains, the Treasury Department and the IRS have determined that it is generally appropriate to treat an opt-out payment that is made available under an unconditional opt-out arrangement in the same manner as a salary reduction contribution for purposes of determining an employee's required contribution under sections 36B and 5000A and any related consequences under sections 4980H(b) and 6056. Accordingly, Notice 2015-87 provides that the Treasury Department and the IRS intend to propose regulations reflecting this rule and to request comments on those regulations. For this purpose, an unconditional opt-out arrangement refers to an arrangement providing payments conditioned solely on an employee declining coverage under employer-sponsored coverage and not on an employee satisfying any other meaningful requirement related to the provision of health care to employees, such as a requirement to provide proof of coverage through a plan of a spouse's employer.

Notice 2015-87 also provides that the Treasury Department and the IRS anticipate requesting comments on the treatment of conditional opt-out arrangements, meaning opt-out arrangements under which payments are conditioned not only on the employee declining employer-sponsored coverage but also on satisfaction of one or more additional meaningful conditions (such as the employee providing proof of enrollment in coverage provided by a spouse's employer or other coverage).

Notice 2015-87 provides that, until the applicability date of any final regulations (and in any event for plan years beginning before 2017), individuals may treat opt-out payments made available under unconditional opt-out arrangements as increasing the employee's required contribution for purposes of sections 36B and 5000A.² In

² Notice 2015-87 also provides that the Treasury Department and the IRS anticipate that the regulations generally will apply only for periods after the issuance of final regulations and that for the period prior to the applicability date of the final regulations, employers are not required to increase the amount of an employee's required contribution by the amount of an opt-out payment made available under an opt-out arrangement (other than

addition, for the same period, an individual who can demonstrate that he or she meets the condition(s) (in addition to declining the employer's health coverage) that must be satisfied to receive an opt-out payment (such as demonstrating that the employee has coverage under a spouse's group health plan) may treat the amount of the conditional opt-out payment as increasing the employee's required contribution for purposes of sections 36B and 5000A. See the section of this preamble entitled "*Effective/Applicability Date*" for additional related discussion.

Notice 2015-87 included a request for comments on opt-out arrangements. The Treasury Department and the IRS received a number of comments, and the comments are discussed in section 2.f. of this preamble entitled "*Opt-out arrangements and an employee's required contribution.*"

Information Reporting

Section 36B(f)(3) provides that Exchanges must report to the IRS and to taxpayers certain information required to administer the premium tax credit. Section 1.36B-5(c)(1) provides that the information required to be reported annually includes (1) identifying information for each enrollee, (2) identifying information for the coverage, (3) the amount of enrollment premiums and advance credit payments for the coverage, (4) the premium for the benchmark plan used to calculate the amount of the advance credit payments made on behalf of the taxpayer or other enrollee, if advance credit payments were made, and the benchmark plan premium that would apply to all individuals enrolled in the coverage if advance credit payments were not made, and (5) the dates the coverage started and ended. Section 1.36B-5(c)(3)(i) provides that an Exchange must report this information for each family enrolled in the coverage.

Explanation of Provisions

1. *Effective/Applicability Date*

Except as otherwise provided in this section, these regulations are proposed to apply for taxable years beginning after December 31, 2016. As indicated in

a payment made available under a non-relief-eligible opt-out arrangement) for purposes of section 6056 (Form 1095-C), and an opt-out payment made available under an opt-out arrangement (other than a payment made available under a non-relief-eligible opt-out arrangement) will not be treated as increasing an employee's required contribution for purposes of any potential consequences under section 4980H(b). For a discussion of non-relief-eligible opt-out arrangements see Notice 2015-87, Q&A-9.

this section, taxpayers may rely on certain provisions of the proposed regulations for taxable years ending after December 31, 2013. In addition, several rules are proposed to apply for taxable years beginning after December 31, 2018. See the later section of this preamble entitled “*Effective/Applicability Date*” for information on the applicability date for the regulations on opt-out arrangements.

2. Eligibility

a. Applicable Taxpayers

To avoid repayments of advance credit payments for taxpayers who experience an unforeseen decline in income, the existing regulations provide that if an Exchange determines at enrollment that the taxpayer’s household income will be at least 100 percent but will not exceed 400 percent of the applicable FPL, the taxpayer will not lose his or her status as an applicable taxpayer solely because household income for the year turns out to be below 100 percent of the applicable FPL. To reduce the likelihood that individuals who recklessly or intentionally provide inaccurate information to an Exchange will benefit from an Exchange determination, the proposed regulations provide that a taxpayer whose household income is below 100 percent of the FPL for the taxpayer’s family size is not treated as an applicable taxpayer if, with intentional or reckless disregard for the facts, the taxpayer provided incorrect information to an Exchange for the year of coverage.

b. Exchange Determination of Ineligibility for Medicaid or CHIP

Similar to the rule for taxpayers who received the benefit of advance credit payments but ended the taxable year with household income below 100 percent of the applicable FPL, the existing regulations do not require a repayment of advance credit payments for taxpayers with household income within the range for eligibility for certain government-sponsored programs if an Exchange determined or considered (within the meaning of 45 CFR 155.302(b)) the taxpayer or a member of the taxpayer’s family to be ineligible for the program. To reduce the likelihood that individuals who recklessly or intentionally provide inaccurate information to an Exchange will benefit from an Exchange determination, the proposed regulations provide that an individual who was determined or considered by an Exchange to be ineligible for Medicaid, CHIP, or a similar program (such as a

Basic Health Program) may be treated as eligible for coverage under the program if, with intentional or reckless disregard for the facts, the individual (or a person claiming a personal exemption for the individual) provided incorrect information to the Exchange.

c. Nonappropriated Fund Health Benefits Program

The existing regulations under section 36B provide that government-sponsored programs described in section 5000A(f)(1)(A), which include the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 1587 note), are not eligible employer-sponsored plans. However, § 1.5000A–2(c)(2) provides that, because the Nonappropriated Fund Health Benefits Program (Program) is offered by an instrumentality of the Department of Defense to its employees, the Program is an eligible employer-sponsored plan. The proposed regulations conform the section 36B regulations to the section 5000A regulations and provide that the Program is treated as an eligible employer-sponsored plan for purposes of determining if an individual is eligible for minimum essential coverage under section 36B. Thus, if coverage under the Program does not provide minimum value (under § 1.36B–2(c)(3)(vi)) or is not affordable (under § 36B–2(c)(3)(v)) for an individual who does not enroll in the coverage, he or she is not treated as eligible for minimum essential coverage under the Program for purposes of premium tax credit eligibility.

d. Eligibility for Employer-Sponsored Coverage for Months During a Plan Year

The existing regulations under section 36B provide that an individual is eligible for minimum essential coverage through an eligible employer-sponsored plan if the individual had the opportunity to enroll in the plan and the plan is affordable and provides minimum value. The Treasury Department and the IRS are aware that in some instances individuals may not be allowed an annual opportunity to decide whether to enroll in eligible employer-sponsored coverage. This lack of an annual opportunity to enroll in employer-sponsored coverage should not limit an individual’s annual choice from available coverage options through the Marketplace with the possibility of benefitting from the premium tax credit. Thus, the proposed regulations clarify that if an individual declines to enroll in employer-sponsored coverage for a

plan year and does not have the opportunity to enroll in that coverage for one or more succeeding plan years, for purposes of section 36B, the individual is treated as ineligible for that coverage for the succeeding plan year or years for which there is no enrollment opportunity.³

e. Excepted Benefits

Under section 36B and § 1.36B–2(c)(3)(vii)(A), an individual is treated as eligible for minimum essential coverage through an eligible employer-sponsored plan if the individual actually enrolls in the coverage, even if the coverage is not affordable or does not provide minimum value. Although health coverage that consists solely of excepted benefits may be a group health plan and, therefore, is an eligible employer-sponsored plan under section 5000A(f)(2) and § 1.5000A–2(c)(1), section 5000A(f)(3) provides that health coverage that consists solely of excepted benefits is not minimum essential coverage. Therefore, individuals enrolled in a plan consisting solely of excepted benefits still must obtain minimum essential coverage to satisfy the individual shared responsibility provision. The proposed regulations clarify that for purposes of section 36B an individual is considered eligible for coverage under an eligible employer-sponsored plan only if that plan is minimum essential coverage. Accordingly, an individual enrolled in or offered a plan consisting solely of excepted benefits is not denied the premium tax credit by virtue of that excepted benefits offer or coverage. Taxpayers may rely on this rule for all taxable years beginning after December 31, 2013.

f. Opt-Out Arrangements and an Employee’s Required Contribution

Sections 1.36B–2(c)(3)(v) and 1.5000A–3(e)(3)(ii)(A) provide that, in determining whether employer-sponsored coverage is affordable to an employee, an employee’s required contribution for the coverage includes the amount by which the employee’s salary would be reduced to enroll in the

³ Note that for purposes of section 4980H, in general, an applicable large employer will not be treated as having made an offer of coverage to a full-time employee for a plan year if the employee does not have an effective opportunity to elect to enroll in the coverage at least once with respect to the plan year. For this purpose, a plan year must be twelve consecutive months, unless a short plan year of less than twelve consecutive months is permitted for a valid business purpose. For additional rules on the definition of “offer” and “plan year” under section 4980H, see §§ 54.4980H–1(a)(35), 54.4980H–4(b), and 54.4980H–5(b).

coverage.⁴ If an employer makes an opt-out payment available to an employee, the choice between cash and health coverage presented by the opt-out arrangement is analogous to the cash-or-coverage choice presented by the option to pay for coverage by salary reduction. In both cases, the employee may purchase the employer-sponsored coverage only at the price of forgoing a specified amount of cash compensation that the employee would otherwise receive—salary, in the case of a salary reduction, or an equal amount of other compensation, in the case of an opt-out payment. Therefore, the economic cost to the employee of the employer-sponsored coverage is the same under both arrangements. Accordingly, the employee's required contribution generally should be determined similarly regardless of the type of payment that an employee must forgo.

Notice 2015–87 requested comments on the proposed treatment of opt-out arrangements outlined in Q&A–9 of that notice. Several commenters objected to the proposal that the amount of an available unconditional opt-out payment increases the employee's required contribution on the basis that forgoing opt-out payments as part of enrolling in coverage has not traditionally been viewed by employers or employees as economically equivalent to making a salary reduction election and that such a rule would discourage employers from making opt-out payments available. None of the commenters, however, offered a persuasive economic basis for distinguishing unconditional opt-out payments from other compensation that an employee must forgo to enroll in employer-sponsored coverage, such as a salary reduction. Because forgoing an unconditional opt-out payment is economically equivalent to forgoing salary pursuant to a salary reduction election, and because §§ 1.36B–2(c)(3)(v) and 1.5000A–3(e)(3)(ii)(A) provide that the employee's required contribution includes the amount of any salary reduction, the proposed regulations adopt the approach described in Notice 2015–87 for opt-out payments made available under

unconditional opt-out arrangements and provide that the amount of an opt-out payment made available to the employee under an unconditional opt-out arrangement increases the employee's required contribution.⁵

Notice 2015–87 provides that, for periods prior to the applicability date of any final regulations, employers are not required to increase the amount of an employee's required contribution by amounts made available under an opt-out arrangement for purposes of section 4980H(b) or section 6056 (in particular Form 1095–C, *Employer-Provided Health Insurance Offer and Coverage*), except that, for periods after December 16, 2015, the employee's required contribution must include amounts made available under an unconditional opt-out arrangement that is adopted after December 16, 2015. However, Notice 2015–87 provided that, for this purpose, an opt-out arrangement will not be treated as adopted after December 16, 2015, under limited circumstances, including in cases in which a board, committee, or similar body or an authorized officer of the employer specifically adopted the opt-out arrangement before December 16, 2015.

Some commenters requested clarification that an unconditional opt-out arrangement that is required under the terms of a collective bargaining agreement in effect before December 16, 2015, should be treated as having been adopted prior to December 16, 2015, and that amounts made available under such an opt-out arrangement should not be included in an employee's required contribution for purposes of sections 4980H(b) or 6056 through the expiration of the collective bargaining agreement that provides for the opt-out arrangement. The Treasury Department and the IRS now clarify that, under Notice 2015–87, for purposes of sections 4980H(b) and 6056, an unconditional opt-out arrangement that is required under the terms of a collective bargaining agreement in effect before December 16, 2015, will be treated as having been adopted prior to December 16, 2015. In addition, until the later of (1) the beginning of the first plan year

that begins following the expiration of the collective bargaining agreement in effect before December 16, 2015 (disregarding any extensions on or after December 16, 2015), or (2) the applicability date of these regulations with respect to sections 4980H and 6056, employers participating in the collective bargaining agreement are not required to increase the amount of an employee's required contribution by amounts made available under such an opt-out arrangement for purposes of sections 4980H(b) or 6056 (Form 1095–C). The Treasury Department and the IRS further adopt these commenters' request that this treatment apply to any successor employer adopting the opt-out arrangement before the expiration of the collective bargaining agreement in effect before December 16, 2015 (disregarding any extensions on or after December 16, 2015). Commenters raised the issue of whether other types of agreements covering employees may need a similar extension of the relief through the end of the agreement's term. The Treasury Department and the IRS request comments identifying the types of agreements raising this issue due to their similarity to collective bargaining agreements because, for example, the agreement is similar in scope to a collective bargaining agreement, binding on the parties involved for a multi-year period, and subject to a statutory or regulatory regime.

Several commenters suggested that, notwithstanding the proposal on unconditional opt-out arrangements, the amount of an opt-out payment made available should not increase an employee's required contribution if the opt-out payment is conditioned on the employee having minimum essential coverage through another source, such as a spouse's employer-sponsored plan. These commenters argued that the amount of such a conditional opt-out payment should not affect the affordability of an employer's offer of employer-sponsored coverage for an employee who does not satisfy the applicable condition because that employee is ineligible to receive the opt-out payment. Moreover, commenters argued that an employee who satisfies the condition (that is, who has alternative minimum essential coverage) is ineligible for the premium tax credit and does not need to determine the affordability of the employer's coverage offer. Thus, the commenters asserted, an amount made available under such an arrangement should be excluded from the required contribution.

While it is clear that the availability of an unconditional opt-out payment increases an individual's required

⁴ Section 5000A(e)(1)(C) and § 1.5000A–3(e)(3)(ii)(B) provide that, for purposes of the individual shared responsibility provision, the required contribution for individuals eligible to enroll in employer coverage because of a relationship to an employee (related individual) is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all related individuals who are included in the employee's family and are not otherwise exempt under § 1.5000A–3.

⁵ To distinguish between opt-out payments and employer contributions to a section 125 cafeteria plan (which in some cases could be paid in cash to an employee who declines coverage in the health plan or other available benefits), the proposed regulations further clarify that an amount provided as an employer contribution to a cafeteria plan and that may be used by the employee to purchase minimum essential coverage is not an opt-out payment, whether or not the employee may receive the amount as a taxable benefit. This provision clarifies that the effect on an employee's required contribution of employer contributions to a cafeteria plan is determined under § 1.36B–2(c)(3)(v)(A)(6) rather than § 1.36B–2(c)(3)(v)(A)(7).

contribution, the effect of the availability of a conditional opt-out payment is less obvious. In particular, under an unconditional opt-out arrangement, an individual who enrolls in the employer coverage loses the opt-out payment as a direct result of enrolling in the employer coverage. By contrast, in the case of a conditional opt-out arrangement, the availability of the opt-out payment may depend on information that is not generally available to the employer (who, if it is an applicable large employer, must report the required contribution under section 6056 and whose potential liability under section 4980H may be affected). Because of this difficulty of ascertaining which individuals could have met the condition and, therefore, would actually forgo the opt-out payment when enrolling in employer-sponsored coverage, it generally is not feasible to have a rule under which the required contribution perfectly captures the cost of coverage for each specific individual offered a conditional opt-out payment.

Similarly, another way to view opt-out payments that are conditioned on alternative coverage is that, rather than raising the cost to the employee of the employer's coverage, they reduce the cost to the employee of the alternative coverage. However, because employers generally do not have information about the existence and cost of other options available to the individual, it is not practical to take into account any offer of coverage other than the offer made by the employer in determining the required contribution with respect to the employer coverage (that is, the coverage that the employee must decline to receive the opt-out payment).

While commenters indicated that the required contribution with respect to the employer coverage does not matter for an individual enrolled in any other minimum essential coverage because the individual would be ineligible for the premium tax credit, this statement is not true if the other coverage is individual market coverage. In particular, while enrollment in most types of minimum essential coverage results in an individual being ineligible for a premium tax credit, that is not the case for coverage in the individual market. Moreover, for individual market coverage offered through a Marketplace, the required contribution with respect to the employer coverage frequently will be relevant in determining whether the individual is eligible for a premium tax credit. In such cases, as in the case of an unconditional opt-out payment, the availability of a conditional opt-out payment effectively increases the cost to

the individual of enrolling in the employer coverage (at least relative to Marketplace coverage).

Further, an opt-out arrangement that is conditioned on an employee's ability to obtain other coverage (if that coverage can be coverage in the individual market, whether inside or outside the Marketplace) does not generally raise the issues described earlier in this section of the preamble regarding the difficulty of ascertaining which individuals could meet the condition under a conditional opt-out arrangement. This is because generally all individuals are able to obtain coverage in the individual market, pursuant to the guaranteed issue requirements in section 2702 of the PHS Act. Thus, in the sense that all individuals can satisfy the applicable condition, such an opt-out arrangement is similar to an unconditional opt-out arrangement.

In an effort to provide a workable rule that balances these competing concerns, the proposed regulations provide that amounts made available under conditional opt-out arrangements are disregarded in determining the required contribution if the arrangement satisfies certain conditions (an "eligible opt-out arrangement"), but otherwise the amounts are taken into account. The proposed regulations define an "eligible opt-out arrangement" as an arrangement under which the employee's right to receive the opt-out payment is conditioned on (1) the employee declining to enroll in the employer-sponsored coverage and (2) the employee providing reasonable evidence that the employee and all other individuals for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year or years that begin or end in or with the employer's plan year to which the opt-out arrangement applies (employee's expected tax family) have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the opt-out arrangement applies. For example, if an employee's expected tax family consists of the employee, the employee's spouse, and two children, the employee would meet this requirement by providing reasonable evidence that the employee, the employee's spouse, and the two children, will have coverage under the group health plan of the spouse's

employer for the period to which the opt-out arrangement applies.⁶

The Treasury Department and the IRS invite comments on this proposed rule, including suggestions for other workable rules that result in the required contribution more accurately reflecting the individual's cost of coverage while minimizing undesirable consequences and incentives.

For purposes of the proposed eligible opt-out arrangement rule, reasonable evidence of alternative coverage includes the employee's attestation that the employee and all other members of the employee's expected tax family, if any, have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) or other reasonable evidence. Notwithstanding the evidence of alternative coverage required under the arrangement, to qualify as an eligible opt-out arrangement, the arrangement must also provide that any opt-out payment will not be made (and the payment must not in fact be made) if the employer knows or has reason to know that the employee or any other member of the employee's expected tax family does not have (or will not have) the required alternative coverage. An eligible opt-out arrangement must also require that the evidence of coverage be provided no less frequently than every plan year to which the eligible opt-out arrangement applies, and that the evidence be provided no earlier than a reasonable period before the commencement of the period of coverage to which the eligible opt-out arrangement applies. Obtaining the reasonable evidence (such as an attestation) as part of the regular annual open enrollment period that occurs within a few months before the commencement of the next plan year of employer-sponsored coverage meets this reasonable period requirement. Alternatively, the eligible opt-out arrangement would be permitted to require evidence of alternative coverage to be provided later, such as after the plan year starts, which would enable the employer to require evidence that the employee and other members of the

⁶ The Treasury Department and the IRS note that if an opt-out payment is conditioned on an employee obtaining individual market coverage, that opt-out arrangement could act as a reimbursement arrangement for some or all of the employee's premium for that individual market coverage; therefore, the opt-out arrangement could operate as an employer payment plan as discussed in Notice 2015-87, Notice 2015-17, 2015-14 I.R.B. 845, and Notice 2013-54, 2013-40 I.R.B. 287. Nothing in these proposed regulations is intended to affect the prior guidance on employer payment plans.

employee's expected tax family have already obtained the alternative coverage.

Commenters on Notice 2015–87 generally stated that typical conditions under an opt-out arrangement include a requirement that the employee have alternative coverage through employer-sponsored coverage of a spouse or another relative, such as a parent. Provided that, as required under the opt-out arrangement, the employee provided reasonable evidence of this alternative coverage for the employee and the other members of the employee's expected tax family, and met the related conditions described in this preamble, these types of opt-out arrangements would be eligible opt-out arrangements, and opt-out payments made available under such arrangements would not increase the employee's required contribution.

The Treasury Department and the IRS did not receive comments on opt-out arrangements indicating that the meaningful conditions imposed include any requirement other than one relating to alternative coverage. Therefore, the proposed rules do not address other opt-out conditions and would not treat an opt-out arrangement based on other conditions as an eligible opt-out arrangement. However, the Treasury Department and the IRS invite comments on whether opt-out payments are made subject to additional types of conditions in some cases, whether those types of conditions should be addressed in further guidance, and, if so, how.

One commenter suggested that, if opt-out payments conditioned on alternative coverage are not included in an employee's required contribution, rules will be needed for cases in which an employee receives an opt-out payment and that employee's alternative coverage subsequently terminates. The commenter suggested that, in that case, the termination of the alternative coverage should have no impact on the determination of the employee's required contribution for the employer-sponsored coverage from which the employee opted out. In response, under the proposed regulations, provided that the reasonable evidence requirement is met, the amount of an opt-out payment made available under an eligible opt-out arrangement may continue to be excluded from the employee's required contribution for the remainder of the period of coverage to which the opt-out payment originally applied. The opt-out payment may be excluded for this period even if the alternative coverage subsequently terminates for the employee or any other member of the employee's expected tax family,

regardless of whether the opt-out payment is required to be adjusted or terminated due to the loss of alternative coverage, and regardless of whether the employee is required to provide notice of the loss of alternative coverage to the employer.

The Treasury Department and the IRS are aware that the way in which opt-out arrangements affect the calculation of affordability is important not only to an employee and the other members of the employee's expected tax family in determining whether they may be eligible for a premium tax credit or whether an individual may be exempt under the individual shared responsibility provisions, but also to an employer subject to the employer shared responsibility provisions under section 4980H in determining whether the employer may be subject to an assessable payment under section 4980H(b). An employer subject to the employer shared responsibility provisions will be subject to a payment under section 4980H(b) only with respect to a full-time employee who receives a premium tax credit, and an employee will not be eligible for the premium tax credit if the employer's offer of coverage was affordable and provided minimum value.⁷ Commenters expressed concern that if the rule adopted for conditional opt-outs required an employee to provide reasonable evidence that the employee has or will have minimum essential coverage, the employer may not know whether the employee is being truthful and has obtained (or will obtain) such coverage, or how long such coverage will continue. Under these proposed regulations, however, the employee's required contribution will not be increased by an opt-out payment made available under an eligible opt-out arrangement, provided that the arrangement provides that the employer makes the payment only if the employee provides reasonable evidence of alternative coverage and the employer does not know or have reason to know that the employee or any other member of the employee's expected tax family fails or will fail to meet the requirement to have alternative coverage (other than individual market coverage, whether or not obtained through the Marketplace).

Some commenters requested exceptions for special circumstances

⁷ The affordability rules under section 36B, including rules regarding opt-out payments, may also affect the application of section 4980H(a) because one element that is required for an applicable large employer to be subject to an assessable payment under section 4980H(a) is that at least one full-time employee must receive the premium tax credit.

from the general rule that the employee's required contribution is increased by the amount of an opt-out payment made available. These circumstances include (1) conditional opt-out payments that are required under the terms of a collective bargaining agreement and (2) opt-out payments that are below a de minimis amount. Regarding opt-out arrangements contained in collective bargaining agreements, the Treasury Department and the IRS anticipate that the proposed treatment of eligible opt-out arrangements, generally, will address the concerns raised in the comments. Accordingly, the Treasury Department and the IRS do not propose to provide a permanent exception for opt-out arrangements provided under collective bargaining agreements. Earlier in this section of the preamble, however, the Treasury Department and the IRS clarify and expand the transition relief provided under Notice 2015–87 for opt-out arrangements provided under collective bargaining agreements in effect before December 16, 2015. As for an exception for de minimis amounts, the Treasury Department and the IRS decline to adopt such an exception because there is neither a statutory nor an economic basis for establishing a de minimis threshold under which an unconditional opt-out payment would be excluded from the employee's required contribution.

g. Effective Date of Eligibility for Minimum Essential Coverage When Advance Credit Payments Discontinuance Is Delayed

Section 36B and the regulations under section 36B provide that an individual who may enroll in minimum essential coverage outside the Marketplace (other than individual market coverage) for a month is generally not allowed a premium tax credit for that month. Consequently, individuals enrolled in a qualified health plan with advance credit payments must return to the Exchange to report eligibility for other minimum essential coverage so the Exchange can discontinue the advance credit payments for Marketplace coverage. Similarly, individuals enrolled in a qualified health plan with advance credit payments may be determined eligible for coverage under a government-sponsored program, such as Medicaid. In some cases, individuals may inform the Exchange of their opportunity to enroll in other minimum essential coverage or receive approval for coverage under a government-sponsored program after the time for which the Exchange can discontinue advance credit payments for the next

month. Because taxpayers should generally not have to repay the advance credit payments for that next month in these circumstances, the proposed regulations provide a rule for situations in which an Exchange's discontinuance of advance credit payments is delayed. Under the proposed regulations, if an individual who is enrolled in a qualified health plan for which advance credit payments are made informs the Exchange that the individual is or will soon be eligible for other minimum essential coverage and that advance credit payments should be discontinued, but the Exchange does not discontinue advance credit payments for the first calendar month beginning after the month the individual notifies the Exchange, the individual is treated as eligible for the other minimum essential coverage no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other minimum essential coverage. Similarly, if a determination is made that an individual is eligible for Medicaid or CHIP but advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the determination. Taxpayers may rely on this rule for all taxable years beginning after December 31, 2013.

3. Premium Assistance Amount

a. Payment of Taxpayer's Share of Premiums for Advance Credit Payments Following Appeal Determinations

Under § 1.36B-3(c)(1)(ii), a month in which an individual who is enrolled in a qualified health plan is a coverage month for the individual only if the taxpayer's share of the premium for the individual's coverage for the month is paid by the unextended due date of the taxpayer's income tax return for the year of coverage, or the premium is fully paid by advance credit payments.

One of the functions of an Exchange is to make determinations as to whether an individual who enrolls in a qualified health plan is eligible for advance credit payments for the coverage. If an Exchange determines that the individual is not eligible for advance credit payments, the individual may appeal that decision. An individual who is initially determined ineligible for advance credit payments, does not enroll in a qualified health plan under the contested determination, and is later determined to be eligible for advance credit payments through the appeals

process, may elect to be retroactively enrolled in a health plan through the Exchange. In that case, the individual is treated as having been enrolled in the qualified health plan from the date on which the individual would have enrolled had he or she initially been determined eligible for advance credit payments. If retroactively enrolled, the deadline for paying premiums for the retroactive coverage may be after the unextended due date for filing an income tax return for the year of coverage. Consequently, the proposed regulations provide that a taxpayer who is eligible for advance credit payments pursuant to an eligibility appeal for a member of the taxpayer's coverage family who, based on the appeals decision, retroactively enrolls in a qualified health plan, is considered to have met the requirement in § 1.36B-3(c)(1)(ii) for a month if the taxpayer pays the taxpayer's share of the premium for coverage under the plan for the month on or before the 120th day following the date of the appeals decision. Taxpayers may rely on this rule for all taxable years beginning after December 31, 2013.

b. Month That Coverage Is Terminated

Section 1.36B-3(d)(2) provides that if a qualified health plan is terminated before the last day of a month, the premium assistance amount for the month is the lesser of the enrollment premiums for the month (reduced by any amounts that were refunded), or the excess of the benchmark plan premium for a full month of coverage over the full contribution amount for the month. Section 1.36B-3(c)(2) provides that an individual whose enrollment in a qualified health plan is effective on the date of the individual's birth or adoption, or placement for foster care, or upon the effective date of a court order, is treated as enrolled as of the first day of the month and, therefore, the month of enrollment may be a coverage month. The regulations, however, do not expressly address how the premium assistance amount is computed when a covered individual disenrolls before the last day of a month but the plan is not terminated because other individuals remain enrolled. For purposes of the premium tax credit, the premium assistance amount for an individual who is not enrolled for an entire month should be the same regardless of the circumstances causing the partial-month coverage, provided that the individual was enrolled, or is treated as enrolled, as of the first day of the month (that is, so long as the month is a coverage month). Accordingly, to provide consistency for all individuals who have

a coverage month that is less than a full calendar month, the proposed regulations provide that the premium assistance amount for a month is the lesser of the enrollment premiums for the month (reduced by any amounts that were refunded), or the excess of the benchmark plan premium over the contribution amount for the month. Taxpayers may rely on this rule for all taxable years beginning after December 31, 2013.

4. Benchmark Plan Premium

a. Effective/Applicability Date of Benchmark Plan Rules

The rules relating to the benchmark plan in this section are proposed to apply for taxable years beginning after December 31, 2018.

b. Pediatric Dental Benefits

Under section 1311(d)(2)(B) of the Affordable Care Act, only qualified health plans, including stand-alone dental plans offering pediatric dental benefits, may be offered through a Marketplace. In general, a qualified health plan is required to provide coverage for all ten essential health benefits described in section 1302(b) of the Affordable Care Act, including pediatric dental coverage. However, under section 1302(b)(4)(F), a plan that does not provide pediatric dental benefits may nonetheless be a qualified health plan if it covers each essential health benefit described in section 1302(b) other than pediatric dental benefits and if it is offered through a Marketplace in which a stand-alone dental plan offering pediatric dental benefits is offered as well.

Section 36B(b)(3)(E) and § 1.36B-3(k) provide that if an individual enrolls in both a qualified health plan and a stand-alone dental plan, the portion of the premium for the stand-alone dental plan properly allocable to pediatric dental benefits is treated as a premium payable for the individual's qualified health plan. Thus, in determining a taxpayer's premium assistance amount for a month in which a member of the taxpayer's coverage family is enrolled in a stand-alone dental plan, the taxpayer's enrollment premium includes the portion of the premium for the stand-alone dental plan allocable to pediatric dental benefits. The existing regulations do not provide a similar adjustment for the taxpayer's applicable benchmark plan premium to reflect the cost of pediatric dental benefits in cases where the second-lowest cost silver plan does not provide pediatric dental benefits.

Section 36B(b)(3)(B) provides that the applicable benchmark plan with respect

to a taxpayer is the second lowest cost silver plan available through the applicable Marketplace that provides “self-only coverage” or “family coverage,” depending generally on whether the coverage family includes one or more individuals. Neither the Code nor the Affordable Care Act defines the terms “self-only coverage” or “family coverage” for this purpose.

Under the existing regulations, the references in section 36B(b)(3)(B) to plans that provide self-only coverage and family coverage are interpreted to refer to all qualified health plans offered through the applicable Marketplace, regardless of whether the coverage offered by those plans includes all ten essential health benefits. Because qualified health plans that do not offer pediatric dental benefits tend to be cheaper than qualified health plans that cover all ten essential health benefits, the second lowest-cost silver plan (and therefore the premium tax credit) for taxpayers purchasing coverage through a Marketplace in which stand-alone dental plans are offered is likely to not account for the cost of obtaining pediatric dental coverage.

The Treasury Department and the IRS believe that the current rule frustrates the statute’s goal of making coverage that provides the essential health benefits affordable to individuals eligible for the premium tax credit. Accordingly, the proposed regulations reflect a modification in the interpretation of the terms “self-only coverage” and “family coverage” in section 36B(b)(3)(B) to refer to coverage that provides each of the essential health benefits described in section 1302(b) of the Affordable Care Act. This coverage may be obtained from either a qualified health plan alone or from a qualified health plan in combination with a stand-alone dental plan. In particular, self-only coverage refers to coverage obtained from such plans where the coverage family is a single individual. Similarly, family coverage refers to coverage obtained from such plans where the coverage family includes more than one individual.

Consistent with this interpretation, the proposed regulations provide that for taxable years beginning after December 31, 2018, if an Exchange offers one or more silver-level qualified health plans that do not cover pediatric dental benefits, the applicable benchmark plan is determined by ranking (1) the premiums for the silver-level qualified health plans that include pediatric dental benefits offered by the Exchange and (2) the aggregate of the premiums for the silver-level qualified health plans offered by the Exchange

that do not include pediatric dental benefits plus the portion of the premium allocable to pediatric dental benefits for stand-alone dental plans offered by the Exchange. In constructing this ranking, the premium for the lowest-cost silver plan that does not include pediatric dental benefits is added to the premium allocable to pediatric dental benefits for the lowest cost stand-alone dental plan, and similarly, the premium for the second lowest-cost silver plan that does not include pediatric dental benefits is added to the premium allocable to pediatric dental benefits for the second lowest-cost stand-alone dental plan. The second lowest-cost amount from this combined ranking is the taxpayer’s applicable benchmark plan premium.

c. Coverage Family Members Residing in Different Locations

Under § 1.36B–3(f), a taxpayer’s applicable benchmark plan is the second lowest cost silver plan offered at the time a taxpayer or family member enrolls in a qualified health plan through the Exchange for the rating area where the taxpayer resides. Under § 1.36B–3(f)(4), if members of a taxpayer’s family reside in different states and enroll in separate qualified health plans, the premium for the taxpayer’s applicable benchmark plan is the sum of the premiums for the applicable benchmark plans for each group of family members living in the same state.

Referring to the residence of the taxpayer to establish the cost for a benchmark health plan is appropriate when the taxpayer and all members of the taxpayer’s coverage family live in the same location because it reflects the cost of available coverage for the taxpayer’s coverage family. However, because premiums and plan availability may vary based on location, the existing rule for a taxpayer whose family members reside in different locations in the same state may not accurately reflect the cost of available coverage. In addition, the rules for calculating the premium tax credit should operate the same for families residing in multiple locations within a state and families residing in multiple states. Accordingly, § 1.36B–3(f)(4) of the proposed regulations provides that if a taxpayer’s coverage family members reside in multiple locations, whether within the same state or in different states, the taxpayer’s benchmark plan is determined based on the cost of available coverage in the locations where members of the taxpayer’s coverage family reside. In particular, if members of a taxpayer’s coverage family reside in different locations, the

taxpayer’s benchmark plan premium is the sum of the premiums for the applicable benchmark plans for each group of coverage family members residing in different locations, based on the plans offered to the group through the Exchange for the rating area where the group resides. If all members of a taxpayer’s coverage family reside in a single location that is different from where the taxpayer resides, the taxpayer’s benchmark plan premium is the premium for the applicable benchmark plan for the coverage family, based on the plans offered to the taxpayer’s coverage family through the Exchange for the rating area where the coverage family resides.

d. Aggregation of Silver-Level Policies

Section 1.36B–3(f)(3) provides that if one or more silver-level plans offered through an Exchange do not cover all members of a taxpayer’s coverage family under one policy (for example, because an issuer will not cover a taxpayer’s dependent parent on the same policy the taxpayer enrolls in), the premium for the applicable benchmark plan may be the premium for a single policy or for more than one policy, whichever is the second lowest-cost silver option. This rule does not specify which combinations of policies must be taken into account for this purpose, suggesting that all such combinations must be considered, which is unduly complex for taxpayers, difficult for Exchanges to implement, and difficult for the IRS to administer. Accordingly, to clarify and simplify the benchmark premium determination for situations in which a silver-level plan does not cover all the members of a taxpayer’s coverage family under one policy, the proposed regulations delete the existing rule and provide a new rule in its place.

Under the proposed regulations, if a silver-level plan offers coverage to all members of a taxpayer’s coverage family who reside in the same location under a single policy, the plan premium taken into account for purposes of determining the applicable benchmark plan is the premium for that policy. In contrast, if a silver-level plan would require multiple policies to cover all members of a taxpayer’s coverage family who reside in the same location, the plan premium taken into account for purposes of determining the applicable benchmark plan is the sum of the premiums for self-only policies under the plan for each member of the coverage family who resides in the same location. Under the proposed regulations, similar rules would apply to the portion of premiums for stand-alone dental plans allocable to pediatric

dental coverage taken into account for purposes of determining the premium for a taxpayer's applicable benchmark plan.

Comments are requested on the rule contained in the proposed regulations, as well as on an alternative rule under which the plan premium taken into account for purposes of determining a taxpayer's applicable benchmark plan would be equal to the sum of the self-only policies under a plan for each member of the taxpayer's coverage family, regardless of whether all members of the taxpayer's coverage family could be covered under a single policy under the plan.

e. Silver-Level Plan Not Available for Enrollment

Section 1.36B-3(f)(5) provides that if a qualified health plan is closed to enrollment for a taxpayer or a member of the taxpayer's coverage family, that plan is disregarded in determining the taxpayer's applicable benchmark plan. Similarly, § 1.36B-3(f)(6) provides that a plan that is the applicable benchmark plan for a taxpayer does not cease to be the applicable benchmark plan solely because the plan or a lower cost plan terminates or closes to enrollment during the taxable year. Because stand-alone dental plans are considered in determining a taxpayer's applicable benchmark plan under the proposed regulations, the proposed regulations provide consistency in the treatment of qualified health plans and stand-alone dental plans that are closed to enrollment or that terminate during the taxable year.

f. Only One Silver-Level Plan Offered to the Coverage Family

In general, § 1.36B-3(f)(1) provides that a taxpayer's applicable benchmark plan is the second lowest-cost silver-level plan available to the taxpayer for self-only or family coverage. However, for taxpayers who reside in certain locations, only one silver-level plan providing such coverage may be available. Section 1.36B-3(f)(8) of the proposed regulations clarifies that if there is only one silver-level qualified health plan offered through the Exchange that would cover all members of the taxpayer's coverage family (whether under one policy or multiple policies), that silver-level plan is used for purposes of the taxpayer's applicable benchmark plan. Similarly, if there is only one stand-alone dental plan offered through the Exchange that would cover all members of the taxpayer's coverage family (whether under one policy or multiple policies), the portion of the premium of that plan that is allocable to

pediatric dental benefits is used for purposes of determining the taxpayer's applicable benchmark plan.

5. Reconciliation of Advance Credit Payments

Section 301.6011-8 provides that a taxpayer who receives the benefit of advance credit payments 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) and reconcile the advance credit payments. In addition, the regulations under section 36B provide that if advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attests to the Exchange to the intention to claim a personal exemption deduction for the individual as part of the determination that the taxpayer is eligible for advance credit payments for coverage of the individual must reconcile the advance credit payments.

Questions have been raised concerning how these two rules apply, and consequently which individual must reconcile advance credit payments, when a taxpayer (a parent, for example) attests that he or she will claim a personal exemption deduction for an individual, the advance payments are made with respect to coverage for the individual, the taxpayer does not claim a personal exemption deduction for the individual, and the individual does not file a tax return for the year. The intent of the existing regulation is that the taxpayer, not the individual for whose coverage advance credit payments were made, must reconcile the advance credit payments in situations in which a taxpayer attests to the intention to claim a personal exemption for the individual and no one claims a personal exemption deduction for the individual. Consequently, the proposed regulations clarify that if advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attests to the Exchange to the intention to claim a personal exemption deduction for the individual, not the individual for whose coverage the advance credit payments were made, must file a tax return and reconcile the advance credit payments.

6. Information Reporting

a. Two or More Families Enrolled in Single Qualified Health Plan

Section 1.36B-3(h) provides that if a qualified health plan covers more than one family under a single policy (for example, a plan covers a taxpayer and

the taxpayer's child who is 25 and not a dependent of the taxpayer), the premium tax credit is computed for each applicable taxpayer covered by the plan. In addition, in computing the tax credit for each taxpayer, premiums for the qualified health plan the taxpayers purchase (the enrollment premiums) are allocated to each taxpayer in proportion to the premiums for each taxpayer's applicable benchmark plan.

The existing regulations provide that the Exchange must report the enrollment premiums for each family, but do not specify the manner in which the Exchange must divide the enrollment premiums among the families enrolled in the policy. Consequently, the proposed regulations clarify that when multiple families enroll in a single qualified health plan and advance credit payments are made for the coverage, the enrollment premiums reported by the Exchange for each family is the family's allocable share of the enrollment premiums, which is based on the proportion of each family's applicable benchmark plan premium.

b. Partial Months of Enrollment

The existing regulations do not specify how the enrollment premiums and benchmark plan premiums are reported in cases in which one or more individuals is enrolled or disenrolled in coverage mid-month. To ensure that this reporting is consistent with the rules for calculating the premium assistance amounts for partial months of coverage, the proposed regulations provide that, if an individual is enrolled in a qualified health plan after the first day of a month, generally no value should be reported for the individual's enrollment premium or benchmark plan premium for that month. However, if an individual's coverage in a qualified health plan is terminated before the last day of a month, or an individual is enrolled in coverage after the first day of a month and the coverage 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, an Exchange must report the premium for the applicable benchmark plan for a full month of coverage (excluding the premium allocated to benefits in excess of essential health benefits). In addition, the proposed regulations provide that the Exchange must report the enrollment premiums for the month (excluding the premium allocated to benefits in excess of essential health benefits), reduced by any amount that was refunded due to the plan's termination.

c. Use of Electronic Media

Section 301.6011-2(b) provides that if the use of certain forms, including the Form 1095 series, is required by the applicable regulations or revenue procedures for the purpose of making an information return, the information required by the form must be submitted on magnetic media. Form 1095-A should not have been included in § 301.6011-2 because Form 1095-A is not an information return. Consequently, the proposed regulations replace the general reference in § 301.6011-2(b) to the forms in the 1095 series with specific references to Forms 1095-B and 1095-C, but not Form 1095-A.

Effective/Applicability Date

Except as otherwise provided, these regulations are proposed to apply for taxable years beginning after December 31, 2016. In addition, taxpayers may rely on certain provisions of the proposed regulations for taxable years ending after December 31, 2013, as indicated earlier in this preamble. In addition, rules relating to the benchmark plan described in section 4 of this preamble are proposed to apply for taxable years beginning after December 31, 2018.

Notwithstanding the proposed applicability date, nothing in the proposed regulations is intended to limit any relief for opt-out arrangements provided in Notice 2015-87, Q&A 9, or in section 2.f of the preamble to these proposed regulations (regarding opt-out arrangements provided for in collective bargaining agreements). For purposes of sections 36B and 5000A, although under the proposed regulations amounts made available under an eligible opt-out arrangement are not added to an employee's required contribution, for periods before the final regulations are applicable and, if later, through the end of the most recent plan year beginning before January 1, 2017, an individual who can demonstrate that he or she meets the condition for an opt-out payment under an eligible opt-out arrangement is permitted to treat the opt-out payment as increasing the employee's required contribution.⁸

For purposes of the consequences of these regulations under sections 4980H and 6056 (and in particular Form 1095-C), the regulations regarding opt-out arrangements are proposed to be first

applicable for plan years beginning on or after January 1, 2017,⁹ and for the period prior to this applicability date employers are not required to increase the amount of an employee's required contribution by the amount of an opt-out payment made available under an opt-out arrangement (other than a payment made available under a non-relief-eligible opt-out arrangement¹⁰). See also section 2.f of this preamble for transition relief provided under Notice 2015-87 as clarified and expanded for opt-out arrangements contained in collective bargaining agreements in effect before December 16, 2015. See § 601.601(d)(2)(ii)(b).

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 assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations.

It is hereby certified that these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the information collection required under these regulations is imposed under section 36B. Consistent with the statute, the proposed regulations require a person that provides minimum essential coverage to an individual to file a return with the IRS reporting certain information and to furnish a statement to the responsible individual who enrolled an individual or family in the coverage. These regulations merely provide the method of filing and furnishing returns and statements under section 36B. Moreover, the proposed regulations attempt to minimize the burden associated with this collection of information by limiting reporting to the information that the IRS requires to verify minimum essential coverage and administer tax credits.

Based on these facts, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required.

Pursuant to section 7805(f) of the Code, this notice of proposed

rulemaking has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the IRS as prescribed in this preamble under the **ADDRESSES** heading. Treasury and the IRS request comments on all aspects of the proposed rules. All comments will be available at www.regulations.gov or upon request. A public hearing will be scheduled if requested in writing by any person who timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal authors of these proposed regulations are Shareen S. Pflanz 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 the development of the regulations.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 301

Employment taxes, Estate taxes, Excise taxes, Gift taxes, Income taxes, Penalties, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 301 are proposed to be amended as follows:

PART 1—INCOME TAXES

■ **Paragraph 1.** The authority citation for part 1 is amended by adding entries in numerical order to read in part as follows:

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

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

- 1. Adding the entries for §§ 1.36B-2(b)(6)(i) and (ii).
- 2. Adding entries for §§ 1.36B-2(c)(3)(v)(A)(7), (v)(A)(7)(i), (ii), (iii)(A), (iii)(B), (iii)(C), and (iv).
- 3. Redesignating entry for § 1.36B-2(c)(4) as (c)(5) and adding new entries for § 1.36B-2(c)(4), (c)(4)(i), (ii), (ii)(A), and (ii)(B).

⁸For periods prior to the applicability date, an individual who cannot demonstrate that he or she meets the condition for an opt-out payment under an eligible opt-out arrangement is not permitted to treat the opt-out payment as increasing the employee's required contribution.

⁹Notice 2015-87, Q&A 9 provides that the Treasury Department and the IRS anticipate that the regulations on opt-out arrangements generally will apply only for periods after the issuance of final regulations. The Treasury Department and the IRS anticipate finalizing these regulations prior to the end of 2016.

¹⁰For a discussion of non-relief-eligible opt-out arrangements see Notice 2015-87, Q&A-9.

- 4. Redesignating entry for § 1.36B–3(c)(4) as (c)(5) and adding a new entry for § 1.36B–3(c)(4).
- 5. Revising entries for §§ 1.36B–3(d)(1) and (d)(2).
- 6. Revising entries for §§ 1.36B–3(f)(3), (4), (5), (6), and (7).
- 7. Adding entries for §§ 1.36B–3(f)(8), (9), and (10).
- 8. Adding entries for §§ 1.36B–5(c)(3)(iii).

The revisions and additions read as follows:

§ 1.36B–0 Table of contents.

* * * * *
 § 1.36B–2 Eligibility for premium tax credit.

- * * * * *
- (b) * * *
- (6) * * *
- (i) In general.
- (ii) Exceptions.
- * * * * *
- (c) * * *
- (3) * * *
- (v) * * *
- (A) * * *
- (7) Opt-out arrangements.
- (i) In general.
- (ii) Eligible opt-out arrangements.
- (iii) Definitions.
- (A) Opt-out payment.
- (B) Opt-out arrangement.
- (C) Eligible opt-out arrangement.
- (iv) Examples.

- * * * * *
- (4) Special eligibility rules.
- (i) Related individuals not claimed as a personal exemption deduction.
- (ii) Exchange unable to discontinue advance credit payments.
- (A) In general.
- (B) Medicaid or CHIP.

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

- * * * * *
- (c) * * *
- (4) Appeals of coverage eligibility.
- (d) * * *
- (1) Premium assistance amount.
- (2) Examples.
- * * * * *
- (f) * * *
- (3) Silver-level plan not covering pediatric dental benefits.
- (4) Family members residing in different locations.
- (5) Single or multiple policies needed to cover the family.
- (i) Policy covering a taxpayer's family.
- (ii) Policy not covering a taxpayer's family.
- (6) Plan not available for enrollment.
- (7) Benchmark plan terminates or closes to enrollment during the year.
- (8) Only one silver-level plan offered to the coverage family.
- (9) Effective date.
- (10) Examples.

§ 1.36B–5 Information reporting by Exchanges.

* * * * *

- (c) * * *
- (3) * * *
- (iii) Partial month of coverage.
- (A) In general.
- (B) Certain mid-month enrollments.
- * * * * *
- **Par. 3.** Section 1.36B–1 is amended by revising paragraphs (l), (m), and (o) to read as follows:

§ 1.36B–1 Premium tax credit definitions.

(l) *Self-only coverage.* Self-only coverage means health insurance that covers one individual and provides coverage for the essential health benefits as defined in section 1302(b)(1) of the Affordable Care Act (42 U.S.C. 18022).

(m) *Family coverage.* Family coverage means health insurance that covers more than one individual and provides coverage for the essential health benefits as defined in section 1302(b)(1) of the Affordable Care Act (42 U.S.C. 18022).

(o) *Effective/applicability date.* Except for paragraphs (l) and (m), this section applies to taxable years ending after December 31, 2013. Paragraphs (l) and (m) of this section apply to taxable years beginning after December 31, 2018. Paragraphs (l) and (m) of § 1.36B–1 as contained in 26 CFR part I edition revised as of April 1, 2016, apply to taxable years ending after December 31, 2013, and beginning before January 1, 2019.

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

- 1. Revise paragraph (b)(6) introductory text, (b)(6)(i) and (ii).
- 2. Adding three new sentences to the end of paragraph (c)(2)(v).
- 3. Revising paragraph (c)(3)(i).
- 4. Revising paragraph (c)(3)(iii)(A).
- 5. Adding three new sentences to the end of paragraph (c)(3)(v)(A)(3).
- 6. Adding new paragraphs (c)(3)(v)(A)(7)
- 7. Revising paragraph (c)(4).
- 8. Adding a new paragraph (e).

§ 1.36B–2 Eligibility for premium tax credit.

* * * * *

(b) * * *

(6) *Special rule for taxpayers with household income below 100 percent of the Federal poverty line for the taxable year—(i) In general.* A taxpayer (other than a taxpayer described in paragraph (b)(5) of this section) whose household income for a taxable year is less than 100 percent of the Federal poverty line for the taxpayer's family size is treated as an applicable taxpayer for the taxable year if—

(A) The taxpayer or a family member enrolls in a qualified health plan

through an Exchange for one or more months during the taxable year;

(B) An Exchange estimates at the time of enrollment that the taxpayer's household income will be at least 100 percent but not more than 400 percent of the Federal poverty line for the taxable year;

(C) Advance credit payments are authorized and paid for one or more months during the taxable year; and

(D) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was at least 100 but not more than 400 percent of the Federal poverty line for the taxpayer's family size.

(ii) *Exceptions.* This paragraph (b)(6) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange for the year of coverage. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows the information provided to the Exchange is inaccurate.

(c) * * *

(2) * * *

(v) * * * This paragraph (c)(2)(v) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange for the year of coverage. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that information provided to the Exchange is inaccurate.

(3) * * *

(i) *In general.* For purposes of section 36B, an employee who may enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2) and the regulations under that section) that is minimum essential coverage, and an individual who may enroll in the plan because of a relationship to the employee (a related individual), are eligible for minimum essential coverage under the plan for any month only if the plan is affordable and provides minimum value. Except for the Nonappropriated Fund Health Benefits

Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Pub. L. 103-337; 10 U.S.C. 1587 note), government-sponsored minimum essential coverage is not an eligible employer-sponsored plan. The Nonappropriated Fund Health Benefits Program of the Department of Defense is considered eligible employer-sponsored coverage, but not government-sponsored coverage, for purposes of determining if an individual is eligible for minimum essential coverage under this section.

* * * * *

(iii) * * *

(A) *Failure to enroll in plan.* An employee or related individual may be eligible for minimum essential coverage under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph (c)(3)(iii)(A) applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

* * * * *

(v) * * *

(A) * * *

(3) * * * This paragraph (c)(3)(v)(A)(3) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning the portion of the annual premium for coverage for the employee or related individual under the plan. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that the information provided to the Exchange is inaccurate.

* * * * *

(7) *Opt-out arrangements—(i) In general.* Except as otherwise provided in this paragraph (c)(3)(v)(A)(7), the amount of an opt-out payment made available to an employee under an opt-out arrangement increases the employee's required contribution for purposes of determining the

affordability of the eligible employer-sponsored plan to which the opt-out arrangement relates, regardless of whether the employee enrolls in the eligible employer-sponsored plan or declines to enroll in that coverage and is paid the opt-out payment.

(ii) *Eligible opt-out arrangements.* The amount of an opt-out payment made available to an employee under an eligible opt-out arrangement does not increase the employee's required contribution for purposes of determining the affordability of the eligible employer-sponsored plan to which the eligible opt-out arrangement relates, regardless of whether the employee enrolls in the eligible employer-sponsored plan or is paid the opt-out payment.

(iii) *Definitions.* The following definitions apply for purposes of this paragraph (c)(3)(v)(A)(7):

(A) *Opt-out payment.* The term *opt-out payment* means a payment that is available only if an employee declines coverage, including waiving coverage in which the employee would otherwise be enrolled, under an eligible employer-sponsored plan and that is not permitted to be used to pay for coverage under the eligible employer-sponsored plan. An amount provided as an employer contribution to a cafeteria plan that is permitted to be used by the employee to purchase minimum essential coverage is not an opt-out payment, whether or not the employee may receive the amount as a taxable benefit. See paragraph (c)(3)(v)(A)(6) of this section for the treatment of employer contributions to a cafeteria plan.

(B) *Opt-out arrangement.* The term *opt-out arrangement* means the arrangement under which an opt-out payment is made available.

(C) *Eligible opt-out arrangement.* The term *eligible opt-out arrangement* means an arrangement under which an employee's right to receive an opt-out payment is conditioned on the employee providing reasonable evidence that the employee and all other individuals for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year or years that begin or end in or with the employer's plan year to which the opt-out arrangement applies (employee's expected tax family) have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the opt-out arrangement applies. For this purpose, reasonable evidence of alternative coverage may include the

employee's attestation that the employee and all other members of the employee's expected tax family have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) for the relevant period. Regardless of the evidence of alternative coverage required under the arrangement, to be an eligible opt-out arrangement, the arrangement must provide that the opt-out payment will not be made, and the employer in fact must not make the payment, if the employer knows or has reason to know that the employee or any other member of the employee's expected tax family does not have or will not have the alternative coverage. The arrangement must also require that the evidence of the alternative coverage be provided no less frequently than every plan year to which the eligible opt-out arrangement applies, and that it must be provided no earlier than a reasonable period of time before the commencement of the period of coverage to which the eligible opt-out arrangement applies. If the reasonable evidence (such as an attestation) is obtained as part of the regular annual open enrollment period that occurs within a few months before the commencement of the next plan year of employer-sponsored coverage, it will qualify as being provided no earlier than a reasonable period of time before commencement of the applicable period of coverage. An eligible opt-out arrangement is also permitted to require evidence of alternative coverage to be provided at a later date, such as after the plan year starts, which would enable the employer to require evidence that the employee and all other members of the employee's expected tax family have already obtained the alternative coverage. Nothing in this rule prohibits an employer from requiring reasonable evidence of alternative coverage other than an attestation in order for an employee to qualify for an opt-out payment under an eligible opt-out arrangement. Further, provided that the reasonable evidence requirement is met, the amount of an opt-out payment made available under an eligible opt-out arrangement continues to be excluded from the employee's required contribution for the remainder of the period of coverage to which the opt-out payment originally applied even if the alternative coverage subsequently terminates for the employee or for any other member of the employee's expected tax family, regardless of whether the opt-out payment is required to be adjusted or terminated due to the loss of alternative coverage, and

regardless of whether the employee is required to provide notice of the loss of alternative coverage to the employer.

(iv) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3)(v)(A)(7). In each example, the eligible employer-sponsored plan's plan year is the calendar year.

Example 1. Taxpayer B is an employee of Employer X, which offers its employees coverage under an eligible employer-sponsored plan that requires B to contribute \$3,000 for self-only coverage. X also makes available to B a payment of \$500 if B declines to enroll in the eligible employer-sponsored plan. Therefore, the \$500 opt-out payment made available to B under the opt-out arrangement increases B's required contribution under X's eligible employer-sponsored plan from \$3,000 to \$3,500, regardless of whether B enrolls in the eligible employer-sponsored plan or declines to enroll and is paid the opt-out payment.

Example 2. The facts are the same as in *Example 1*, except that availability of the \$500 opt-out payment is conditioned not only on B declining to enroll in X's eligible employer-sponsored plan but also on B providing reasonable evidence no earlier than the regular annual open enrollment period for the next plan year that B and all other members of B's expected tax family are or will be enrolled in minimum essential coverage through another source (other than coverage in the individual market, whether or not obtained through the Marketplace). B's expected tax family consists of B and B's spouse, C, who is an employee of Employer Y. During the regular annual open enrollment period for the upcoming plan year, B declines coverage under X's eligible employer-sponsored plan and provides X with reasonable evidence that B and C will be enrolled in Y's employer-sponsored plan, which is minimum essential coverage. The opt-out arrangement provided by X is an eligible opt-out arrangement, and, therefore, the \$500 opt-out payment made available to B does not increase B's required contribution under X's eligible employer-sponsored plan. B's required contribution for self-only coverage under X's eligible employer-sponsored plan is \$3,000.

Example 3. The facts are the same as in *Example 2*, except that B and C have two children that B expects to claim as dependents for the taxable year that coincides with the upcoming plan year. During the regular annual open enrollment period for the upcoming plan year, B declines coverage under X's eligible employer-sponsored plan and provides X with reasonable evidence that B and C will be enrolled in Y's employer-sponsored plan, which is minimum essential coverage. However, B does not provide reasonable evidence that B's children will be enrolled in minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace); therefore, X determines B is not eligible for the opt-out payment, and B does not receive it. The \$500 opt-out payment made available under the opt-out arrangement does not

increase B's required contribution under X's eligible employer-sponsored plan because the opt-out arrangement provided by X is an eligible opt-out arrangement. B's required contribution for self-only coverage under X's eligible employer-sponsored plan is \$3,000.

Example 4. Taxpayer D is married and is employed by Employer Z, which offers its employees coverage under an eligible employer-sponsored plan that requires D to contribute \$2,000 for self-only coverage. Z also makes available to D a payment of \$300 if D declines to enroll in the eligible employer-sponsored plan and provides reasonable evidence no earlier than the regular annual open enrollment period for the next plan year that D is or will be enrolled in minimum essential coverage through another source (other than coverage in the individual market, whether or not obtained through the Marketplace); the opt-out arrangement is not conditioned on whether the other members of D's expected tax family have other coverage. This opt-out arrangement is not an eligible opt-out arrangement because it does not condition the right to receive the opt-out payment on D providing reasonable evidence that D and the other members of D's expected tax family have (or will have) minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace). Therefore, the \$300 opt-out payment made available to D under the opt-out arrangement increases D's required contribution under Z's eligible employer-sponsored plan. D's required contribution for self-only coverage under Z's eligible employer-sponsored plan is \$2,300.

* * * * *

(4) *Special eligibility rules—(i) Related individual not claimed as a personal exemption deduction.* An individual who may enroll in minimum essential coverage because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction under section 151, is treated as eligible for minimum essential coverage under the coverage only for months that the related individual is enrolled in the coverage.

(ii) *Exchange unable to discontinue advance credit payments—(A) In general.* If an individual who is enrolled in a qualified health plan for which advance credit payments are made informs the Exchange that the individual is or will soon be eligible for other minimum essential coverage and that advance credit payments should be discontinued, but the Exchange does not discontinue advance credit payments for the first calendar month beginning after the month the individual informs the Exchange, the individual is treated as eligible for the other minimum essential coverage no earlier than the first day of the second calendar month beginning after the first month the

individual may enroll in the other minimum essential coverage.

(B) *Medicaid or CHIP.* If a determination is made that an individual who is enrolled in a qualified health plan for which advance credit payments are made is eligible for Medicaid or CHIP but the advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for the Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination.

* * * * *

(e) *Effective/applicability date.* (1) Except as provided in paragraph (f)(2) of this section, this section applies to taxable years ending after December 31, 2013.

(2) Paragraph (b)(6)(ii), the last three sentences of paragraph (c)(2)(v), paragraph (c)(3)(i), paragraph (c)(3)(iii)(A), the last three sentences of paragraph (c)(3)(v)(A)(3), paragraph (c)(3)(v)(A)(7), and paragraph (c)(4) of this section apply to taxable years beginning after December 31, 2016. Paragraphs (b)(6), (c)(3)(i), (c)(3)(iii)(A), and (c)(4) of § 1.36B-2 as contained in 26 CFR part I edition revised as of April 1, 2016, apply to taxable years ending after December 31, 2013, and beginning before January 1, 2017.

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

- 1. Redesignating paragraph (c)(4) as paragraph (c)(5) and adding a new paragraph (c)(4).
- 2. Revising paragraph (d)(1).
- 3. Revising paragraph (d)(2).
- 4. Revising paragraph (f)
- 5. Adding paragraph (n).

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

* * * * *

(c) * * *

(4) *Appeals of coverage eligibility.* A taxpayer who is eligible for advance credit payments pursuant to an eligibility appeal decision implemented under 45 CFR 155.545(c)(1)(ii) for coverage of a member of the taxpayer's coverage family who, based on the appeal decision, retroactively enrolls in a qualified health plan is considered to have met the requirement in paragraph (c)(1)(ii) of this section for a month if the taxpayer pays the taxpayer's share of the premiums for coverage under the plan for the month on or before the 120th day following the date of the appeals decision.

* * * * *

(d) * * *

(1) *Premium assistance amount.* The premium assistance amount for a coverage month is the lesser of—

(i) The premiums for the month, reduced by any amounts that were refunded, 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) *Examples.* The following examples illustrate the rules of paragraph (d)(1) of this section.

Example 1. Taxpayer Q is single and has no dependents. Q enrolls in a qualified health plan with a monthly premium of \$400. Q's monthly benchmark plan premium is \$500, and his monthly contribution amount is \$80. Q's premium assistance amount for a coverage month is \$400 (the lesser of \$400, Q's monthly enrollment premium, and \$420, the difference between Q's monthly benchmark plan premium and Q's contribution amount).

Example 2. (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 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 paragraph (d)(1) of this section, R's premium assistance amount for September is the lesser of the enrollment premiums for the month, reduced by any amounts that were refunded (\$300 (\$450 – \$150)) or the difference between the benchmark plan premium and the contribution amount for the month (\$420). R's premium assistance amount for September is \$300, the lesser of \$420 and \$300.

Example 3. The facts are the same as in Example 2 of this paragraph (d)(2), except that the qualified health plan issuer does not refund any enrollment premiums for September. Under paragraph (d)(1) of this section, R's premium assistance amount for September is \$420, the lesser of \$450 and \$420.

* * * * *

(f) *Applicable benchmark plan—(1) In general.* Except as otherwise provided in this paragraph (f), the applicable benchmark plan for each coverage month is the second-lowest-cost silver plan (as described in section 1302(d)(1)(B) of the Affordable Care Act

(42 U.S.C. 18022(d)(1)(B))) offered to the taxpayer's coverage family through the Exchange for the rating area where the taxpayer resides for—

(i) Self-only coverage for a taxpayer—

(A) Who computes tax under section 1(c) (unmarried individuals other than surviving spouses and heads of household) and is not allowed a deduction under section 151 for a dependent for the taxable year;

(B) Who purchases only self-only coverage for one individual; or

(C) Whose coverage family includes only one individual; and

(ii) Family coverage for all other taxpayers.

(2) *Family coverage.* The applicable benchmark plan for family coverage is the second lowest-cost silver plan that would cover the members of the taxpayer's coverage family (such as a plan covering two adults if the members of a taxpayer's coverage family are two adults).

(3) *Silver-level plan not covering pediatric dental benefits.* If one or more silver-level qualified health plans offered through an Exchange do not cover pediatric dental benefits, the premium for the applicable benchmark plan is determined based on the second lowest-cost option among—

(i) The silver-level qualified health plans that provide pediatric dental benefits offered by the Exchange to the members of the coverage family;

(ii) The lowest-cost silver-level qualified health plan that does not provide pediatric dental benefits offered by the Exchange to the members of the coverage family in conjunction with the lowest-cost portion of the premium for a stand-alone dental plan (within the meaning of section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)) offered through the Exchange to the members of the coverage family that is properly allocable to pediatric dental benefits determined under guidance issued by the Secretary of Health and Human Services; and

(iii) The second-lowest-cost silver-level qualified health plan that does not provide pediatric dental benefits offered by the Exchange to the members of the coverage family in conjunction with the second-lowest-cost portion of the premium for a stand-alone dental plan (within the meaning of section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)) offered through the Exchange to the members of the coverage family that is properly allocable to pediatric dental benefits determined under guidance issued by the Secretary of Health and Human Services.

(4) *Family members residing in different locations.* If members of a taxpayer's coverage family reside in different locations, the taxpayer's benchmark plan premium is the sum of the premiums for the applicable benchmark plans for each group of coverage family members residing in different locations, based on the plans offered to the group through the Exchange where the group resides. If all members of a taxpayer's coverage family reside in a single location that is different from where the taxpayer resides, the taxpayer's benchmark plan premium is the premium for the applicable benchmark plan for the coverage family, based on the plans offered through the Exchange to the taxpayer's coverage family for the rating area where the coverage family resides.

(5) *Single or multiple policies needed to cover the family—(i) Policy covering a taxpayer's family.* If a silver-level plan or a stand-alone dental plan offers coverage to all members of a taxpayer's coverage family who reside in the same location under a single policy, the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the applicable benchmark plan under paragraphs (f)(1), (f)(2), and (f)(3) of this section is the premium for this single policy.

(ii) *Policy not covering a taxpayer's family.* If a silver-level qualified health plan or a stand-alone dental plan would require multiple policies to cover all members of a taxpayer's coverage family who reside in the same location (for example, because of the relationships within the family), the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the applicable benchmark plan under paragraphs (f)(1), (f)(2), and (f)(3) of this section is the sum of the premiums (or allocable portion thereof, in the case of a stand-alone dental plan) for self-only policies under the plan for each member of the coverage family who resides in the same location.

(6) *Plan not available for enrollment.* A silver-level qualified health plan or a stand-alone dental plan that is not open to enrollment by a taxpayer or family member at the time the taxpayer or family member enrolls in a qualified health plan is disregarded in determining the applicable benchmark plan.

(7) *Benchmark plan terminates or closes to enrollment during the year.* A silver-level qualified health plan or a stand-alone dental plan that is used for purposes of determining the applicable benchmark plan under this paragraph (f)

for a taxpayer does not cease to be the applicable benchmark plan for a taxable year solely because the plan or a lower cost plan terminates or closes to enrollment during the taxable year.

(8) *Only one silver-level plan offered to the coverage family.* If there is only one silver-level qualified health plan providing pediatric dental benefits, one silver-level qualified health plan not providing pediatric dental benefits, or one stand-alone dental plan offered through an Exchange that would cover all members of a taxpayer's coverage family who reside in the same location (whether under one policy or multiple policies), that plan is used for purposes of determining the taxpayer's applicable benchmark plan.

(9) *Examples.* The following examples illustrate the rules of this paragraph (f). Unless otherwise stated, in each example the plans are open to enrollment to a taxpayer or family member at the time of enrollment and are offered through the Exchange for the rating area where the taxpayer resides:

Example 1. Single taxpayer enrolls in a qualified health plan. Taxpayer A is single, has no dependents, and enrolls in a qualified health plan. The Exchange in the rating area in which A resides offers only silver-level qualified health plans that provide pediatric dental benefits. Under paragraphs (f)(1) and (f)(2) of this section, A's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for A.

Example 2. Single taxpayer enrolls with dependent in a qualified health plan. Taxpayer B is single and claims her daughter, C, as a dependent. B purchases family coverage for herself and C. The Exchange in the rating area in which B and C reside offers qualified health plans that provide pediatric dental benefits but does not offer qualified health plans without pediatric dental benefits. Under paragraphs (f)(1) and (f)(2) of this section, B's applicable benchmark plan is the second lowest-cost silver plan providing family coverage to B and C.

Example 3. Benchmark plan for a coverage family with a family member eligible for pediatric dental benefits. (i) Taxpayer D's coverage family consists of D and D's 10-year old son, E, who is a dependent of D and eligible for pediatric dental benefits. The Exchange in the rating area in which D and E reside offers three silver-level qualified health plans, two of which provide pediatric dental benefits (S1 and S2) and one of which does not (S3), in which D and E may enroll. The Exchange also offers two stand-alone dental plans (DP1 and DP2) available to D and E. The monthly premiums allocable to essential health benefits for the silver-level plans are as follows:

S1—\$1,250
S2—\$1,200
S3—\$1,180

(ii) The monthly premiums, and the portion of the premium allocable to pediatric

dental benefits, for the two dental plans are as follows:

DP1—\$100 (\$25 allocable to pediatric dental benefits)
DP2—\$80 (\$40 allocable to pediatric dental benefits).

(iii) Under paragraph (f)(3) of this section, D's applicable benchmark plan is the second lowest cost option among the following offered by the rating area in which D resides: silver-level qualified health plans providing pediatric dental benefits (\$1,250 for S1 and \$1,200 for S2); the lowest-cost silver-level qualified health plan not providing pediatric dental benefits, in conjunction with the lowest-cost portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits (\$1,180 for S3 in conjunction with \$25 for DP1 = \$1,205); and the second lowest cost silver-level qualified health plan not providing pediatric health benefits, in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan allocable to pediatric dental benefits (\$1,180 for S3 in conjunction with \$40 for DP2 = \$1,220). Under paragraph (f)(8) of this section, S3, as the lone silver-level qualified health plan not providing pediatric dental benefits offered by the Exchange, is treated as the second lowest-cost silver-level qualified health plan not providing pediatric dental benefits. Under paragraph (e) of this section, the adjusted monthly premium for D's applicable benchmark plan is \$1,205.

Example 4. Benchmark plan for a coverage family with no family members eligible for pediatric dental coverage. (i) The facts are the same as in *Example 3*, except Taxpayer D's coverage family consists of D and D's 22-year old son, F, who is a dependent of D and not eligible for pediatric dental coverage and the monthly premiums allocable to essential health benefits for the silver-level plans are as follows:

S1—\$1,210
S2—\$1,190
S3—\$1,180

(ii) Because no one in D's coverage family is eligible for pediatric dental benefits, \$0 of the premium for a stand-alone dental plan is allocable to pediatric dental benefits in determining A's applicable benchmark plan. Consequently, under paragraphs (f)(1), (f)(2), and (f)(3) of this section, D's applicable benchmark plan is the second lowest-cost option among the following options offered by the rating area in which D resides: silver-level qualified health plans providing pediatric dental benefits (\$1,210 for S1 and \$1,190 for S2), the lowest-cost silver-level qualified health plan not providing pediatric dental benefits, in conjunction with the lowest-cost portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits (\$1,180 for S3 in conjunction with \$0 for DP1 = \$1,180), and the second lowest cost silver-level qualified health plan not providing pediatric health benefits, in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan allocable to pediatric dental benefits (\$1,180 for S3 in conjunction with \$0 for DP2 = \$1,180). Under paragraph (e) of this section, the adjusted monthly

premium for D's applicable benchmark plan is \$1,180.

Example 5. Single taxpayer enrolls with dependent and nondependent in a qualified health plan. Taxpayer G is single and resides with his daughter, H, and with his teenage son, I, but may only claim I as a dependent. G, H, and I enroll in coverage through the Exchange in the rating area in which they all reside. The Exchange offers only silver-level plans providing pediatric dental benefits. Under paragraphs (f)(1) and (f)(2) of this section, G's applicable benchmark plan is the second lowest-cost silver plan covering G and I. However, H may qualify for a premium tax credit if H is otherwise eligible. See paragraph (h) of this section.

Example 6. Change in coverage family. Taxpayer J is single and has no dependents when she enrolls in a qualified health plan. The Exchange in the rating area in which she resides offers only silver-level plans that provide pediatric dental benefits. On August 1, J has a child, K, whom she claims as a dependent. J enrolls in a qualified health plan covering J and K effective August 1. Under paragraphs (f)(1) and (f)(2) of this section, J's applicable benchmark plan for January through July is the second lowest-cost silver plan providing self-only coverage for J, and J's applicable benchmark plan for the months August through December is the second lowest-cost silver plan covering J and K.

Example 7. Minimum essential coverage for some coverage months. Taxpayer L claims his daughter, M, as a dependent. L and M enroll in a qualified health plan through an Exchange that offers only silver-level plans that provide pediatric dental benefits. L, but not M, is eligible for government-sponsored minimum essential coverage for September to December. Thus, under paragraph (c)(1)(iii) of this section, January through December are coverage months for M, and January through August are coverage months for L. Because, under paragraphs (d) and (f)(1) of this section, the premium assistance amount for a coverage month is computed based on the applicable benchmark plan for that coverage month, L's applicable benchmark plan for January through August is the second lowest-cost option covering L and M. Under paragraph (f)(1)(i)(C) of this section, L's applicable benchmark plan for September through December is the second lowest-cost silver plan providing self-only coverage for M.

Example 8. Family member eligible for minimum essential coverage for the taxable year. The facts are the same as in *Example 7*, except that L is not eligible for government-sponsored minimum essential coverage for any months and M is eligible for government sponsored minimum essential coverage for the entire year. Under paragraph (f)(1)(i)(C) of this section, L's applicable benchmark plan is the second lowest-cost silver plan providing self-only coverage for L.

Example 9. Benchmark plan premium for a coverage family with family members who reside in different locations. (i) Taxpayer N's coverage family consists of N and her three dependents O, P, and Q. N, O, and P reside together but Q resides in a different location. Under paragraphs (f)(1), (f)(2), and (f)(3) of

this section, the monthly applicable benchmark plan premium for N, O, and P is \$1,000 and the monthly applicable benchmark plan premium for Q is \$220.

(ii) Under paragraph (f)(4) of this section, because the members of N's coverage family reside in different locations, the monthly premium for N's applicable benchmark plan is the sum of \$1,000, the monthly premiums for the applicable benchmark plan for N, O, and P, who reside together, and \$220, the monthly applicable benchmark plan premium for Q, who resides in a different location than N, O, and P. Consequently, the premium for N's applicable benchmark plan is \$1,220.

Example 10. Aggregation of silver-level policies for plans not covering a family under a single policy. (i) Taxpayers R and S are married and live with S's mother, T, whom they claim as a dependent. The Exchange for their rating area offers self-only and family coverage at the silver level through Issuers A, B, and C, which each offer only one silver-level plan. The silver-level plans offered by Issuers A and B do not cover R, S, and T under a single policy. The silver-level plan offered by Issuer A costs the following monthly amounts for self-only coverage of R, S, and T, respectively: \$400, \$450, and \$600. The silver-level plan offered by Issuer B costs the following monthly amounts for self-only coverage of R, S, and T, respectively: \$250, \$300, and \$450. The silver-level plan offered by Issuer C provides coverage for R, S, and T under one policy for a \$1,200 monthly premium.

(ii) Under paragraph (f)(5) of this section, Issuer C's silver-level plan that covers R, S, and T under one policy (\$1,200 monthly premium) and Issuer A's and Issuer B's silver-level plans that do not cover R, S and T under one policy are considered in determining R's and S's applicable benchmark plan. In addition, under paragraph (f)(5)(ii) of this section, in determining R's and S's applicable benchmark plan, the premium taken into account for Issuer A's plan is \$1,450 (the aggregate premiums for self-only policies covering R (\$400), S (\$450), and T (\$600) and the premium taken into account for Issuer B's plan is \$1,000 (the aggregate premiums for self-only policies covering R (\$250), S (\$300), and T (\$450)). Consequently, R's and S's applicable benchmark plan is the Issuer C silver-level plan covering R's and S's coverage family and the premium for their applicable benchmark plan is \$1,200.

Example 11. Benchmark plan premium for a taxpayer with family members who cannot enroll in one policy and who reside in different locations. (i) Taxpayer U's coverage family consists of U, U's mother, V, and U's two daughters, W and X. U and V reside together in Location 1 and W and X reside together in Location 2. The Exchange in the rating area in which U and V reside does not offer a silver-level plan that covers U and V under a single policy, whereas all the silver-level plans offered through the Exchange in the rating area in which W and X reside cover W and X under a single policy. Both Exchanges offer only silver-level plans that provide pediatric dental benefits. The silver plan offered by the Exchange for the rating

area in which U and V reside that would cover U and V under self-only policies with the second-lowest aggregate premium costs \$400 a month for self-only coverage for U and \$600 a month for self-only coverage for V. The monthly premium for the second-lowest cost silver plan covering W and X that is offered by the Exchange for the rating area in which W and X reside is \$500.

(ii) Under paragraph (f)(5)(ii) of this section, because multiple policies are required to cover U and V, the members of U's coverage family who reside together in Location 1, the premium taken into account in determining U's benchmark plan is \$1,000, the sum of the premiums for the second-lowest aggregate cost of self-only policies covering U (\$400) and V (\$600) offered by the Exchange to U and V for the rating area in which U and V reside. Under paragraph (f)(5)(i) of this section, because all silver-level plans offered by the Exchange in which W and X reside cover W and X under a single policy, the premium for W and X's coverage that is taken into account in determining U's benchmark plan is \$500, the second-lowest cost silver policy covering W and X that is offered by the Exchange for the rating area in which W and X reside. Under paragraph (f)(4) of this section, because the members of U's coverage family reside in different locations, U's monthly benchmark plan premium is \$1,500, the sum of the premiums for the applicable benchmark plans for each group of family members residing in different locations (\$1,000 for U and V, who reside in Location 1, plus \$500 for W and X, who reside in Location 2).

Example 12. Qualified health plan closed to enrollment. Taxpayer Y has two dependents, Z and AA. Y, Z, and AA enroll in a qualified health plan through the Exchange for the rating area where the family resides. The Exchange, which offers only qualified health plans that include pediatric dental benefits, offers silver-level plans J, K, L, and M, which are, respectively, the first, second, third, and fourth lowest cost silver plans covering Y's family. When Y's family enrolls, Plan J is closed to enrollment. Under paragraph (f)(6) of this section, Plan J is disregarded in determining Y's applicable benchmark plan, and Plan L is used in determining Y's applicable benchmark plan.

Example 13. Benchmark plan closes to new enrollees during the year. (i) Taxpayers BB, CC, and DD each have coverage families consisting of two adults. In that rating area, Plan 2 is the second lowest cost silver plan and Plan 3 is the third lowest cost silver plan covering the two adults in each coverage family offered through the Exchange. The BB and CC families each enroll in a qualified health plan that is not the applicable benchmark plan (Plan 4) in November during the annual open enrollment period. Plan 2 closes to new enrollees the following June. Thus, on July 1, Plan 3 is the second lowest cost silver plan available to new enrollees through the Exchange. The DD family enrolls in a qualified health plan in July.

(ii) Under paragraphs (f)(1), (f)(2), (f)(3), and (f)(7) of this section, the silver-level plan that BB and CC use to determine their applicable benchmark plan for all coverage months during the year is Plan 2. The

applicable benchmark plan that DD uses to determine DD's applicable benchmark plan is Plan 3, because Plan 2 is not open to enrollment through the Exchange when the DD family enrolls.

Example 14. Benchmark plan terminates for all enrollees during the year. The facts are the same as in *Example 13*, except that Plan 2 terminates for all enrollees on June 30. Under paragraphs (f)(1), (f)(2), (f)(3), and (f)(7) of this section, Plan 2 is the silver-level plan that BB and CC use to determine their applicable benchmark plan for all coverage months during the year, and Plan 3 is the applicable benchmark plan that DD uses.

Example 15. Exchange offers only one silver-level plan. Taxpayer EE's coverage family consists of EE, his spouse FF, and their two dependent children GG and HH, who all reside together. The Exchange for the rating area in which they reside offers only one silver-level plan that EE's family may enroll in and the plan does not provide pediatric dental benefits. The Exchange also offers one stand-alone dental plan in which the family may enroll. Under paragraph (f)(8) of this section, the silver-level plan and the stand-alone dental plan offered by the Exchange are used for purposes of determining EE's applicable benchmark plan under paragraph (f)(3) of this section. Moreover, the lone silver-level plan and the lone stand-alone dental plan offered by the Exchange are used for purposes of determining EE's applicable benchmark plan regardless of whether these plans cover EE's family under a single policy or multiples policies.

* * * * *

(n) *Effective/applicability date.* (1) Except as provided in paragraph (o)(2) of this section, this section applies to taxable years ending after December 31, 2013.

(2) Paragraphs (c)(4) and (d)(2) apply to taxable years beginning after December 31, 2016. Paragraphs (f)(1), (f)(3), (f)(4), (f)(6), (f)(7), (f)(8), and (f)(9) of this section apply to taxable years beginning after December 31, 2018. Paragraphs (c)(4) and (d)(2) of § 1.36B-3 as contained in 26 CFR part I edition revised as of April 1, 2016, apply to taxable years ending after December 31, 2013, and beginning before January 1, 2017. Paragraphs (f)(1), (f)(3), (f)(4), (f)(6), and (f)(7) of § 1.36B-3 as contained in 26 CFR part I edition revised as of April 1, 2016, apply to taxable years ending after December 31, 2013, and beginning before January 1, 2019.

- **Par. 6.** Section 1.36B-5 is amended by:
 - 1. Adding a new sentence to the end of paragraph (c)(3)(i).
 - 2. Adding paragraphs (c)(3)(iii) and (h).

§ 1.36B-5 Information reporting by Exchanges.

* * * * *

(c) * * *

(3) —* * *

(i) * * * If advance credit payments are made for coverage under the plan, the enrollment premiums reported to each family under paragraph (c)(1)(viii) of this section are the premiums allocated to the family under § 1.36B–3(h) (allocating enrollment premiums to each taxpayer in proportion to the premiums for each taxpayer's applicable benchmark plan).

* * * * *

(iii) *Partial month of coverage*—(A) *In general*. Except as provided in paragraph (c)(iii)(B) of this section, if an individual is enrolled in a qualified health plan after the first day of a month, the amount reported for that month under paragraphs (c)(1)(iv), (c)(1)(v), and (c)(1)(viii) of this section is \$0.

(B) *Certain mid-month enrollments*. If an individual's qualified health plan is terminated before the last day of a month, or if an individual is enrolled in coverage after the first day of a month and the coverage 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 amount reported under paragraphs (c)(1)(iv) and (c)(1)(v) of this section is the premium for the applicable benchmark plan for a full month of coverage (excluding the premium allocated to benefits in excess of essential health benefits) and the amount reported under paragraph (c)(1)(viii) of this section is the enrollment premium for the month, reduced by any amounts that were refunded.

* * * * *

(h) *Effective/applicability date*. Except for the last sentence of paragraph (c)(3)(i) of this section and paragraph (c)(3)(iii) of this section, this section applies to taxable years ending after December 31, 2013. The last sentence of paragraph (c)(3)(i) of this section and paragraph (c)(3)(iii) of this section apply to taxable years beginning after December 31, 2016. Paragraph (c)(3)(iii) of § 1.36B–5 as contained in 26 CFR part I edition revised as of April 1, 2016, applies to taxable years ending after December 31, 2013, and beginning before January 1, 2017.

■ **Par. 7.** Section 1.5000A–3 is amended by adding a new paragraph (e)(3)(ii)(G) to read as follows:

§ 1.5000A–3 Exempt individuals.

* * * * *

(e) * * *

(3) * * *

(ii) * * *

(G) *Opt-out arrangements*—(1) *In general*. Except as otherwise provided

in this paragraph (e)(3)(ii)(G), the amount of an opt-out payment made available to an employee under an opt-out arrangement increases the employee's (or related individual's) required contribution for purposes of determining the affordability of the eligible employer-sponsored plan to which the opt-out arrangement relates, regardless of whether the employee (or related individual) enrolls in the eligible employer-sponsored plan or declines to enroll in that coverage and is paid the opt-out payment.

(2) *Eligible opt-out arrangements*. The amount of an opt-out payment made available to an employee under an eligible opt-out arrangement does not increase the employee's (or related individual's) required contribution for purposes of determining the affordability of the eligible employer-sponsored plan to which the eligible opt-out arrangement relates, regardless of whether the employee (or related individual) enrolls in the eligible employer-sponsored plan or is paid the opt-out payment.

(3) *Definitions*. The following definitions apply for purposes of this paragraph (e)(3)(ii)(G):

(A) *Opt-out payment*. The term *opt-out payment* means a payment that is available only if an employee declines coverage, including waiving coverage in which the employee would otherwise be enrolled, under an eligible employer-sponsored plan and that is not permitted to be used to pay for coverage under the eligible employer-sponsored plan. An amount provided as an employer contribution to a cafeteria plan that is permitted to be used by the employee to purchase minimum essential coverage is not an opt-out payment, whether or not the employee may receive the amount as a taxable benefit. See paragraph (e)(3)(ii)(E) of this section for the treatment of employer contributions to a cafeteria plan.

(B) *Opt-out arrangement*. The term *opt-out arrangement* means the arrangement under which an opt-out payment is made available.

(C) *Eligible opt-out arrangement*. The term *eligible opt-out arrangement* means an arrangement under which an employee's right to receive an opt-out payment is conditioned on the employee providing reasonable evidence that the employee and all other individuals for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year or years that begin or end in or with the employer's plan year to which the opt-out arrangement applies (employee's expected tax family) have, or will have, minimum essential

coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the opt-out arrangement applies. For this purpose, reasonable evidence of alternative coverage may include the employee's attestation that the employee and all other members of the employee's expected tax family have, or will have, minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) for the relevant period. Regardless of the evidence of alternative coverage required under the arrangement, to be an eligible opt-out arrangement, the arrangement must provide that the opt-out payment will not be made, and the employer in fact must not make the payment, if the employer knows or has reason to know that the employee or any other member of the employee's expected tax family does not have, or will not have, the alternative coverage. The arrangement must also require that the evidence of the alternative coverage be provided no less frequently than every plan year to which the eligible opt-out arrangement applies, and that it must be provided no earlier than a reasonable period of time before the commencement of the period of coverage to which the eligible opt-out arrangement applies. If the reasonable evidence (such as an attestation) is obtained as part of the regular annual open enrollment period that occurs within a few months before the commencement of the next plan year of employer-sponsored coverage, it will qualify as being provided no earlier than a reasonable period of time before commencement of the applicable period of coverage. An eligible opt-out arrangement is also permitted to require evidence of alternative coverage to be provided at a later date, such as after the plan year starts, which would enable the employer to require evidence that the employee and all other members of the employee's expected tax family have already obtained the alternative coverage. Nothing in this rule prohibits an employer from requiring reasonable evidence of alternative coverage other than an attestation in order for an employee to qualify for an opt-out payment under an eligible opt-out arrangement. Further, provided that the reasonable evidence requirement is met, the amount of an opt-out payment made available under an eligible opt-out arrangement continues to be excluded from the employee's required contribution for the remainder of the period of coverage to which the opt-out payment originally applied even if the

alternative coverage subsequently terminates for the employee or for any other member of the employee's expected tax family, regardless of whether the opt-out payment is required to be adjusted or terminated due to the loss of alternative coverage, and regardless of whether the employee is required to provide notice of the loss of alternative coverage to the employer.

* * * * *

■ **Par. 8.** Section 1.5000A-5 is amended by revising paragraph (c).

§ 1.5000A-5 Administration and procedure.

* * * * *

(c) *Effective/applicability date.* (1) Except as provided in paragraph (c)(2), this section and §§ 1.5000A-1 through 1.5000A-4 apply for months beginning after December 31, 2013.

(2) Paragraph (e)(3)(ii)(G) of § 1.5000A-3 applies to months beginning after December 31, 2016.

■ **Par. 9.** Revise § 1.6011-8 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.* Except as otherwise provided in this paragraph (a), a taxpayer who receives the benefit of advance payments of the premium tax credit under section 36B 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) and reconcile the advance credit payments. However, if advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attests to the Exchange to the intention to claim a personal exemption deduction for the individual as part of the determination that the taxpayer is eligible for advance credit payments must file a tax return and reconcile the advance credit payments.

(b) *Effective/applicability date.* Except as otherwise provided, this section applies for taxable years beginning after December 31, 2016. Paragraph (a) of § 1.6011-8 as contained in 26 CFR part I edition revised as of April 1, 2016, applies to taxable years ending after December 31, 2013, and beginning before January 1, 2017.

§ 301.6011-2 [Amended]

■ **Par. 10.** Section 301.6011-2(b)(1) is amended by adding “1095-B, 1095-C”

after “1094 series”, and removing “1095 series”.

John Dalrymple,

Deputy Commissioner for Services and Enforcement.

[FR Doc. 2016-15940 Filed 7-6-16; 11:15 am]

BILLING CODE 4830-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Part 8

RIN 0930-AA22

Medication Assisted Treatment for Opioid Use Disorders Reporting Requirements

AGENCY: Substance Abuse and Mental Health Services Administration (SAMHSA), HHS.

ACTION: Supplemental notice of proposed rulemaking.

SUMMARY: On March 30, 2016, the U.S. Department of Health and Human Services (HHS) published a Notice of Proposed Rulemaking (NPRM) to increase the highest patient limit for qualified physicians to treat opioid use disorder under section 303(g)(2) of the Controlled Substances Act (CSA). On July 6, 2016, HHS published a final rule based on the NPRM but delayed finalizing the reporting requirements outlined in the NPRM. In this Supplemental Notice of Proposed Rulemaking (SNPRM), HHS seeks further comment on the same reporting requirements outlined in the NPRM. These reporting requirements would require annual reporting by practitioners who are approved to treat up to 275 patients under subpart F to help HHS ensure compliance with the requirements of the “Medication Assisted Treatment for Opioid Use Disorders” final rule published elsewhere in this issue of the **Federal Register**. HHS will consider the public comments on this SNPRM as well as any comments already received on the March 30, 2016 NPRM before issuing a final rule pertaining to the reporting requirements.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 8, 2016.

ADDRESSES: You may submit comments, identified by Regulatory Information Number (RIN) 0930-AA22, by any of the following methods:

- *Electronically: Federal eRulemaking Portal:* Go to <http://www.regulations.gov> and follow the instructions for submitting comments.

- *Regular Mail or Hand Delivery or Courier:* Written comments mailed by regular mail must be sent to the following address ONLY: The Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, Attn: Jinhee Lee, SAMHSA, 5600 Fishers Lane, Room 13E21C, Rockville, Maryland 20857. Please allow sufficient time for mailed comments to be received before the close of the comment period.

- *Express or Overnight Mail:* Written comments sent by hand delivery, or regular, express or overnight mail must be sent to the following address ONLY: The Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, Attn: Jinhee Lee, SAMHSA, 5600 Fishers Lane, Room 13E21C, Rockville, Maryland 20857.

Instructions: To avoid duplication, please submit only one copy of your comments by only one method. All submissions received must include the agency name and docket number or RIN for this rulemaking. All comments received will become a matter of public record and will be posted without change to <http://www.regulations.gov>, including any personal information provided. For detailed instructions on submitting comments and additional information on the rulemaking process and viewing public comments, see the “Public Participation” heading of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: For access to the docket to read background documents or comments received, go to <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT: Jinhee Lee, Pharm.D., Public Health Advisor, Center for Substance Abuse Treatment, 240-276-0545, Email address: WaiverRegulations@samhsa.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose

The purpose of this Supplemental Notice of Proposed Rulemaking (SNPRM) is to solicit additional comment on the proposed reporting requirements in the U.S. Department of Health and Human Services (HHS) March 30, 2016 Notice of Proposed Rulemaking (NPRM) on Medication Assisted Treatment for Opioid Use Disorders under section 303(g)(2) of the Controlled Substances Act (CSA) (81 FR 17639). These requirements will assist HHS in ensuring practitioner compliance with the requirements of 42 CFR part 8, subpart F.