

[4830-01-p]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG-141036-13]

RIN 1545-BL91

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

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains proposed regulations relating to the requirement to maintain minimum essential coverage enacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended by the TRICARE Affirmation Act and Public Law 111-173. These proposed regulations affect individual taxpayers who may be liable for the shared responsibility payment for not maintaining minimum essential coverage. This document also provides notice of a public hearing on these proposed regulations.

DATES: Comments must be received by April 28, 2014. Outlines of topics to be discussed at the public hearing scheduled for May 21, 2014, at 10 a.m., must be received by April 28, 2014.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG-141036-13), room 5205, Internal Revenue Service, PO 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-141036-13), Courier's Desk, Internal Revenue

Service, 1111 Constitution Avenue, NW., Washington, DC, or sent electronically via the Federal eRulemaking Portal at www.regulations.gov (IRS REG-141036-13). The public hearing will be held in the IRS Auditorium, Internal Revenue Building, 1111 Constitution Avenue, NW., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Sue-Jean Kim or John B. Lovelace, (202) 317-7006; concerning the submission of comments, the public hearing, and to be placed on the building access list to attend the public hearing, Oluwafunmilayo Taylor, (202) 317-6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in §1.5000A-3(h)(3) and §1.5000A-4(a)(1) of this notice of proposed rulemaking has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545-0074 in conjunction with the final regulations under section 5000A (TD 9632). The information is necessary to determine whether the individual shared responsibility provision applies to a taxpayer and, if it applies, the amount of the payment. 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 March 28, 2014.

Background

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), added section 5000A to the Internal Revenue Code. Section 5000A was subsequently amended by the TRICARE Affirmation Act of 2010, Public Law 111-159 (124 Stat. 1123) and Public Law 111-173 (124 Stat. 1215). Section 5000A provides that, for months beginning after December 31, 2013, a nonexempt individual must maintain minimum essential coverage or make a shared responsibility payment.

Final regulations under section 5000A (TD 9632) were published on August 30, 2013 (78 FR 53646). The preamble to the final regulations indicates that subsequent proposed regulations will provide that coverage under certain government-sponsored programs is not government-sponsored minimum essential coverage. The preamble to the final regulations also describes rules to be included in subsequent regulations for determining, for purposes of the lack of affordable coverage exemption, the required contribution for individuals eligible to enroll in an eligible employer-sponsored plan that provides employer contributions to health reimbursement arrangements (HRAs) or wellness program incentives. These proposed regulations address these issues, consistent with the rules contemplated in the preamble to the final regulations. In addition, these proposed regulations provide or clarify rules under section 5000A addressing the definition of excepted benefits, hardship exemptions that may be claimed on a Federal income tax return, and the computation of the monthly penalty amount.

Minimum Essential Coverage

Section 5000A(f)(1) enumerates the types of health care coverage that qualify as minimum essential coverage. They include, among others, coverage under specified government-sponsored programs and health benefits coverage that the Secretary of Health and Human Services (HHS), in coordination with the Secretary of the Treasury, recognizes as minimum essential coverage. Under section 5000A(f)(1)(A), specified government-sponsored programs include, among other things, the Medicaid program under title XIX of the Social Security Act and medical coverage under chapter 55 of title 10, United States Code, including the TRICARE program.

Section 1.5000A-2(b)(1)(ii) of the final regulations provides that government-sponsored programs that are minimum essential coverage include the Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1396 and following sections) other than certain Medicaid coverage that may provide limited benefits: (1) optional coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XXI)); (2) optional coverage of tuberculosis-related services under section 1902(a)(10)(A)(ii)(XII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XI)); (3) coverage of pregnancy-related services under section 1902(a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(IX)); and (4) coverage limited to the treatment of emergency medical conditions in accordance with 8 U.S.C. 1611(b)(1)(A), as authorized by section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)).

Excepted Benefits

Under section 5000A(f)(3) and §1.5000A-2(g) of the final regulations, minimum essential coverage does not include any health insurance 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 (42 U.S.C. 300gg-91(c)), or regulations issued under these provisions (45 CFR 148.220) (excepted benefits regulations). In general, excepted benefits are benefits that are limited in scope or are conditional. Under 2791(b)(1) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(1)), health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

Lack of Affordable Coverage Exemption

Section 5000A(e)(1) and §1.5000A-3(e)(1) of the final regulations provide that an individual is exempt for a month when the individual cannot afford minimum essential coverage. For this purpose, an individual cannot afford minimum essential coverage if the individual's required contribution (determined on an annual basis) for minimum essential coverage exceeds a percentage (8 percent for 2014) of the individual's household income for the most recent taxable year for which the Secretary of HHS, in consultation with the Secretary of the Treasury, determines information is available.

For individuals ineligible for coverage under an eligible employer-sponsored plan, the required contribution is the annual premium for the applicable plan reduced by the premium tax credit allowable under section 36B for the taxable year (determined as if

the individual enrolled in a plan through an Exchange for the entire taxable year). The applicable plan is the lowest cost bronze plan available in the Exchange serving the rating area where the individual resides that would cover all members of the individual's nonexempt family taking into account the rating factors that an Exchange would use to determine the cost of coverage. If the Exchange serving the rating area where the individual resides does not offer a single bronze plan that would cover all members of the individual's nonexempt family, the premium for the applicable plan is the sum of the premiums for the lowest cost bronze plans available in the Exchange that provide coverage for all members of the nonexempt family.

Hardship Exemptions

Section 5000A(e)(5) and §1.5000A-3(h)(1) of the final regulations provide that, in general, an individual is exempt for a month that includes a day on which the individual has in effect a hardship exemption certification. A hardship exemption certification is issued by an Exchange under section 1311(d)(4)(H) of the Affordable Care Act (42 U.S.C. 18031(d)(4)(H)) certifying that the individual has suffered a hardship (as that term is defined in 45 CFR 155.605(g)) with respect to the individual's ability to obtain coverage under a qualified health plan. Section 1.5000A-3(h)(3) of the final regulations provides that a taxpayer who meets the requirements of 45 CFR 155.605(g)(3) or 45 CFR 155.605(g)(5) may claim a hardship exemption for a calendar year on a Federal income tax return.

Pursuant to the authority under 45 CFR 155.605(g), the Secretary of HHS has established an additional hardship exemption that applies to individuals enrolling in a qualified health plan through an Exchange prior to the close of the initial open

enrollment period. Specifically, an individual may claim a hardship exemption for the months prior to the effective date of the individual's coverage on a Federal income tax return for 2014 without the need to request an exemption from the Exchange. See HHS Centers for Medicare and Medicaid Services, Shared Responsibility Provision Question and Answer (Oct. 28, 2013).

Monthly Penalty Amount

Under section 5000A(c)(1), the amount of the shared responsibility payment imposed on any taxpayer for any taxable year is equal to the lesser of (A) the sum of monthly penalty amounts for months when one or more failures to maintain minimum essential coverage occurred, or (B) an amount equal to the national average premium for qualified health plans that satisfy requirements enumerated in section 5000A(c).

Under section 5000A(c)(2), the monthly penalty amount, for any month, is 1/12 of the greater of (A) the flat dollar amount, or (B) a specified percentage of the taxpayer's household income over the taxpayer's applicable return filing threshold (as defined in section 6012(a)(1)).

The flat dollar amount is the lesser of (A) the sum of the defined applicable dollar amounts for all individuals in the shared responsibility family who did not have minimum essential coverage in a particular month, or (B) 300 percent of the applicable dollar amount. Under section 5000A(c)(3), the applicable dollar amount is \$95 in 2014, \$325 in 2015, and \$695 in 2016. After 2016, the applicable dollar amount will be indexed by a cost-of-living adjustment.

The specified percentage is 1.0 percent for taxable years beginning in 2014, 2.0 percent for taxable years beginning in 2015, and 2.5 percent for taxable years beginning after 2015.

The final regulations incorporate these provisions.

Explanation of Provisions

- I. Minimum Essential Coverage
- A. Medicaid-related programs
- 1. Coverage for the Medically Needy

The Social Security Act provides states with flexibility to extend Medicaid eligibility to individuals with high medical expenses who would be eligible for Medicaid but for their income level (medically needy individuals). See section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)) and 42 CFR 435.300 and following sections. In general, individuals whose income is in excess of the maximum allowed for Medicaid eligibility but who are otherwise eligible for Medicaid may “spend down” their income, based on incurred medical expenses, and thereby become eligible for the benefits provided for medically needy individuals in the state. States providing coverage to medically needy individuals must establish a “budget period” lasting from one to six months. Eligibility for coverage as a medically needy individual, which must be determined each budget period, is provided only after an individual incurs sufficient medical expenses to spend down to the qualifying income level. Thus, depending on an individual’s medical needs and the options exercised by the state program, eligibility may be assessed as frequently as every month, and an individual may move in and out of coverage for medically needy individuals multiple times in a year. States are

permitted, and some states have adopted the option, to offer benefits to the medically needy that are more limited than the benefits generally provided to Medicaid beneficiaries.

Because the benefits provided to medically needy individuals are not required to be comprehensive, the coverage is analogous to coverage consisting of excepted benefits that is not minimum essential coverage under section 5000A(f)(3). Other types of coverage under government-sponsored programs that potentially provide limited benefits are not minimum essential coverage under the final regulations (for example, the optional coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XXI)), and the optional coverage of tuberculosis-related services under section 1902(a)(10)(A)(ii)(XII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XII)). Accordingly, the proposed regulations provide that coverage for medically needy individuals generally is not government-sponsored minimum essential coverage. To the extent such coverage in a particular state is comprehensive coverage, such coverage may be recognized as minimum essential coverage by the Secretary of HHS, in coordination with the Secretary of the Treasury, under section 5000A(f)(1)(E).

Because individuals receiving medically needy coverage may not know at the time of open enrollment for the 2014 plan year that coverage under the program is not minimum essential coverage, Notice 2014-10 (available at www.irs.gov), (see §601.601(d)(2)(ii)(b) of this chapter), released concurrently with these proposed regulations, provides that a taxpayer is not liable for the shared responsibility payment

for a month in 2014 with respect to individuals in the taxpayer's shared responsibility family who are enrolled in medically needy coverage.

2. Section 1115 Demonstration Projects

Section 1115 of the Social Security Act (42 U.S.C. 1315) authorizes the Secretary of HHS to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program ("Section 1115 demonstration projects"). Some Section 1115 demonstration projects involve waivers of Medicaid requirements that affect individuals eligible under the approved Medicaid state plan (for instance, waivers to permit changes in manners of delivering Medicaid services), but do not change the basic requirement to provide comprehensive Medicaid coverage. Other Section 1115 demonstration projects, authorized under section 1115(a)(2) of the Social Security Act (42 U.S.C. 1315(a)(2)), allow a state to extend benefits to additional populations (expansion populations). Because the expansion populations are not described in approved Medicaid state plans, the coverage authorized under those Section 1115 demonstration projects is not required to be comprehensive and may be limited. Accordingly, the proposed regulations provide that coverage under Section 1115 demonstration projects authorized under section 1115(a)(2) of the Social Security Act generally is not government-sponsored minimum essential coverage. However, comprehensive coverage for expansion populations under certain Section 1115 demonstration programs may be recognized as minimum essential coverage by the Secretary of HHS, in coordination with the Secretary of the Treasury, under section 5000A(f)(1)(E).

The Treasury Department and IRS understand that individuals receiving benefits as part of an expansion population under a demonstration project authorized under section 1115(a)(2) may not know at open enrollment for the 2014 plan year that the coverage they receive under a Section 1115 demonstration project is not minimum essential coverage. Accordingly, Notice 2014-10 (available at www.irs.gov), (see §601.601(d)(2)(ii)(b) of this chapter), released concurrently with these proposed regulations, provides that a taxpayer will not be liable for the shared responsibility payment for a month in 2014 with respect to individuals in the taxpayer's shared responsibility family receiving benefits as part of an expansion population authorized under section 1115(a)(2).

B. Limited-benefit coverage under chapter 55 of title 10, U.S.C.

Similar to Medicaid programs that provide a limited scope of benefits, two types of coverage provided under chapter 55 of Title 10, U.S.C., do not provide a scope of benefits comparable to the full TRICARE program under the same chapter. Under sections 1079(a), 1086(c)(1), and 1086(d)(1) of Title 10, U.S.C., the first type of limited-benefit coverage is provided for certain individuals who are excluded from TRICARE coverage for health care services from private sector providers and only eligible for space available care in a facility of the uniformed services (space available care). There is no guarantee of care and any care received is subject to the availability of space and facilities, as well as the capabilities of the medical and dental staff. Coverage potentially available to an affected individual may not be accessible if there is no space available at the facility where the individual seeks care or treatment. These affected individuals are not entitled to comprehensive health care coverage under

chapter 55 of Title 10, U.S.C., and the Department of Defense has no statutory authority to pay claims for any outside care provided to these individuals.

Under sections 1074a and 1074b of Title 10, U.S.C., the second type of limited-benefit coverage is provided for certain individuals who are not on active duty and are entitled to episodic care for an injury, illness, or disease incurred or aggravated in the line of duty (line-of-duty care). Line-of-duty care is limited to care appropriate for treating the covered injury, illness, or disease. This type of limited-benefit coverage is similar to coverage consisting of excepted benefits, including workers' compensation, that is not minimum essential coverage under section 5000A(f)(3).

Neither of these types of limited-benefit coverage offers beneficiaries coverage for comprehensive medical care. Accordingly, the proposed regulations provide that Military Health System eligibility limited only to space available care and line-of-duty care are not government-sponsored programs providing minimum essential coverage. Because individuals enrolled in space available care or line-of-duty care may not know at open enrollment for the 2014 plan year that space available care and line-of-duty care are not minimum essential coverage, Notice 2014-10 (available at www.irs.gov), (see §601.601(d)(2)(ii)(b) of this chapter), released concurrently with these proposed regulations, provides that a taxpayer is not liable for the shared responsibility payment for a month in 2014 with respect to individuals in the taxpayer's shared responsibility family who are enrolled in either space available care or line-of-duty care.

C. Excepted benefits

Section 5000A(f)(3) and §1.5000A-2(g) of the final regulations provide that minimum essential coverage does not include health insurance coverage that consists

solely of excepted benefits. In the rulemaking process under section 5000A, the Treasury Department and the IRS have provided that minimum essential coverage does not include plans or programs that do not provide a comprehensive scope of benefits. See, for example, §1.5000A-2(b)(1)(ii)(A) describing the Medicaid program for family planning services and §1.5000A-2(b)(1)(v) excluding from the definition of minimum essential coverage medical care for veterans that does not provide comprehensive health care benefits. Consistent with this treatment, the proposed regulations clarify that minimum essential coverage excludes any coverage, whether insurance or otherwise, that consists solely of excepted benefits.

II. Exemption for Individuals Who Cannot Afford Coverage

A. Health reimbursement arrangements

The preamble to the final regulations provides that guidance on how employer contributions to HRAs are counted in determining an employee's or a related individual's required contribution will be consistent with final rulemaking under section 36B. The regulations proposed under section 36B addressing the treatment of employer contributions to HRAs were published on May 3, 2013 (78 FR 25909) (the section 36B proposed regulations). The section 36B proposed regulations provide that amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan are counted toward the employee's required contribution in determining the affordability of the coverage if the employee may use the amounts only for premiums or may choose to use the amounts for either premiums or cost sharing. An HRA generally must be integrated with an eligible employer-sponsored plan to satisfy the market reform provisions imposed by Title I of the Affordable Care

Act. See Notice 2013-54 (2013-40 IRB 287 (September 30, 2013)), (see §601.601(d)(2)(ii)(b) of this chapter), which is available at www.irs.gov.

Similar to the 36B proposed regulations, under these proposed regulations, an employer's new contributions to an HRA are taken into account in determining (in other words, they reduce) an employee's required contribution if the HRA is integrated with an employer-sponsored plan and the employee may use the amounts to pay premiums. Amounts in an HRA that may be used only for cost-sharing are not taken into account when determining affordability because they cannot affect the employee's out-of-pocket cost of acquiring minimum essential coverage.

B. Contributions to a cafeteria plan

Many employers maintain section 125 cafeteria plans under which employees are given the option of making salary reduction contributions toward the cost of nontaxable benefits or receiving an equivalent amount in taxable cash. The nontaxable benefit choices may include both health and non-health benefits. If an employee elects to make salary reduction contributions and to have those amounts applied towards the cost of premiums, those contributions are treated as employee contributions, and the employee's household income is increased by the amount of the contributions for purposes of the affordability determination under section 5000A (e)(1)(A).

Alternatively, employers may make contributions that can be received only in the form of nontaxable benefits under the plan (sometimes referred to as flex contributions). In addition, some employers subsidize benefits available under the section 125 cafeteria plan so that an employee can elect a benefit while making salary reduction contributions in an amount less than the value of the benefit. Some employers will provide

contributions even if the employee declines the subsidized benefit. For example, an employer might offer a benefit with a value of \$10,000 for an employee salary reduction of \$4,000, but provide other benefits with a value of \$3,000 if the employee declines the \$10,000 benefit.

Comments are requested on the treatment of employer contributions under a section 125 cafeteria plan for purposes of section 5000A to the extent employees may not opt to receive the employer contributions as a taxable benefit, such as cash. Specifically, comments are requested regarding how these contributions should be taken into account for purposes of determining the affordability of coverage.

III. Wellness program incentives

A. Individuals eligible for employer-sponsored coverage

The preamble to the final section 5000A regulations provides that guidance on how wellness program incentives are counted in determining the affordability of coverage under section 5000A will be consistent with final rulemaking under section 36B. The proposed section 36B regulations address the treatment of wellness incentives by providing that, for purposes of determining an individual's required contribution for employer-sponsored coverage under section 36B(c)(2)(C)(i), wellness program incentives are treated as earned only if the incentives relate to tobacco use. This rule is consistent with other Affordable Care Act provisions (such as one allowing insurers to charge higher premiums based on tobacco use). Accordingly, these proposed regulations provide that, for purposes of determining for section 5000A an individual's required contribution for coverage under an employer-sponsored plan,

wellness program incentives are treated as earned only if the incentives relate to tobacco use.

B. Individuals ineligible for employer-sponsored coverage

In general, for individuals ineligible for coverage under employer-sponsored plans, the required contribution is the premium for the applicable plan reduced by the maximum amount of any premium tax credit allowable under section 36B for the taxable year. In general, the applicable plan is the lowest cost bronze plan available in the individual market through the Exchange serving the rating area in which the individual resides that would cover all members of the individual's nonexempt family. Pursuant to section 36B(b)(3)(C), the premium tax credit allowable under section 36B is calculated by reference to the adjusted monthly premium for the applicable second lowest cost silver plan without regard to any premium discounts or rebates in a state participating in the wellness discount demonstration project described in section 2705(l) of the Public Health Service Act (42 U.S.C. 300gg-4(l)).

A comment received on previously issued proposed regulations under section 5000A asked that, for purposes of computing the required contribution for an individual not eligible for coverage under an eligible employer-sponsored plan, the applicable plan for an individual residing in a rating area in a state participating in the individual market wellness program demonstration project disregard any premium-based wellness incentive requirements, including incentives relating to tobacco use. Standards and processes implementing the individual market wellness program demonstration project have not yet been established. After the individual market wellness program demonstration project is implemented, additional guidance will be provided on whether

and how individuals residing in a rating area participating in the project will take wellness incentives into account in determining the affordability of their coverage for purposes of section 5000A.

C. Simplified method

Proposed regulations previously issued under section 5000A (78 FR 7314) included an alternative method of identifying the premium for the applicable plan when a single bronze plan is not offered that would cover all members of the nonexempt family. During the comment period to the proposed regulations, questions arose concerning the efficacy of the proposed simplified method, as well as whether an election to use the simplified method should be revocable. The final regulations removed the proposed alternative method, and the Treasury Department and the IRS continue to consider this issue.

A taxpayer may be unable to find a single bronze plan that would cover all members of the taxpayer's nonexempt family. The final regulations provide the general rule that, if the Exchange serving the rating area where the individual resides does not offer a single bronze plan that would cover all members of the taxpayer's nonexempt family, the premium for the applicable plan is the sum of the premiums for the lowest cost bronze plans available in the Exchange that provide coverage for all members of the nonexempt family. The Treasury Department and the IRS request comments on alternative methods for identifying the premium for the applicable plan when a single bronze plan would not cover all members of the taxpayer's nonexempt family.

IV. Hardship Exemptions

The final regulations specify that an individual who meets the requirements of 45 CFR 155.605(g)(3) (relating to individuals with gross income below the applicable return filing threshold who filed a return) or 45 CFR 155.605(g)(5) (relating to the affordability of coverage under an eligible employer-sponsored plan for family members) may claim a hardship exemption for a calendar year on a Federal income tax return. Consistent with guidance released by the Secretary of HHS on October, 28, 2013, the proposed regulations provide that an individual who enrolls in a plan through an Exchange during the open enrollment period for coverage for 2014 may claim a hardship exemption for months in 2014 prior to the effective date of the individual's coverage without obtaining a hardship exemption certification from an Exchange.

If additional situations are identified where an individual should be allowed to claim a hardship exemption without obtaining a hardship exemption certification from an Exchange, the Secretary of HHS and the Secretary of the Treasury will continue to coordinate guidance. To facilitate issuing guidance in this situation, the proposed regulations provide that a taxpayer may claim a hardship exemption on a return if the Secretary of HHS issues published guidance of general applicability describing the hardship and indicating that the hardship can be claimed on a Federal income tax return pursuant to guidance published by the Secretary of the Treasury, and the Secretary of the Treasury issues published guidance of general applicability allowing an individual to claim such hardship exemption on a Federal income tax return without obtaining a hardship exemption from an Exchange.

Monthly Penalty Amounts

The final regulations provide that, for each taxable year, the shared responsibility payment is the lesser of the sum of monthly penalty amounts for each individual in the shared responsibility family or the sum of the monthly national average bronze plan premiums for the shared responsibility family. The monthly penalty amount is computed for the taxpayer, not for each individual in the shared responsibility family. To avoid any confusion about this treatment, the proposed regulations remove from §1.5000A-4(a) the clause "for each individual in the shared responsibility family" and add a reference to the taxpayer on whom the shared responsibility payment is imposed under §1.5000A-1(c).

Applicability Date

These regulations are proposed to apply for months beginning after December 31, 2013.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to the proposed regulations. Pursuant to the Regulatory Flexibility Act (RFA) (5 U.S.C. chapter 6), it is hereby certified that the proposed regulations will not have a significant economic impact on a substantial number of small entities. The applicability of the proposed regulations is limited to individuals, who are not small entities as defined by the RFA (5 U.S.C. 601). Accordingly, the RFA does not apply. Therefore, a regulatory flexibility analysis is not required. Pursuant to section 7805(f) of

the Code, the proposed regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Public Hearing

Before the 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. The Treasury Department 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 has been scheduled for May 21, 2014, beginning at 10 a.m., in the Auditorium, Internal Revenue Building, 1111 Constitution Avenue NW., Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 30 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the "FOR FURTHER INFORMATION CONTACT" section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit electronic or written comments, and an outline of the topics to be discussed and the time to be devoted to each topic (signed original and eight (8) copies) by April 28, 2014. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the

agenda will be available free of charge at the hearing.

Drafting Information

The principal authors of the proposed regulations are Sue-Jean Kim and John B. Lovelace, Office of the Associate Chief Counsel (Income Tax & Accounting). Other personnel from the Treasury Department and the IRS participated in the development of the regulations.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

PART 1—INCOME TAXES

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

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

Par 2. An undesignated center heading is added immediately following §1.1563-4 to read as follows:

Individual Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage

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

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

The revisions and addition read as follows.

§1.5000A-0 Table of contents.

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§1.5000A-2 Minimum essential coverage.

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(b) * * *

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

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§1.5000A-3 Exempt individuals.

* * * * *

(e) * * *

(4) * * *

(ii) * * *

(C) Wellness program incentives.

(D) Credit allowable under section 36B.

(E) Required contribution for part-year period.

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(h) * * *

(3) Hardship exemption without hardship exemption certification.

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

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

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

The revisions read as follows:

§1.5000A-2 Minimum essential coverage.

* * * * *

(b) * * *(1) * * *

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

* * * * *

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

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

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

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

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

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

(vi) Coverage authorized under section 1115(a)(2) of the Social Security Act (42 U.S.C. 1315(a)(2));

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

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

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

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

The revisions and additions read as follows:

§1.5000A-3 Exempt individuals.

* * * * *

(e) * * *

(3) * * *

(ii) * * *

(D) Employer contributions to health reimbursement arrangements. Amounts newly made available for the current plan year under a health reimbursement arrangement that is integrated with an eligible employer-sponsored plan and that an employee may use to pay premiums are taken into account in determining the employee's or a related individual's required contribution.

(E) Wellness program incentives. Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's or a related individual's required contribution to the extent the incentives relate to tobacco use. Wellness program incentives that do not relate to tobacco use are treated as not earned for this purpose.

* * * * *

(4) * * *

(ii) * * *

(C) Wellness programs incentives. [Reserved]

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

* * * * *

(3) Hardship exemption without hardship exemption certification. An individual may claim an exemption without obtaining a hardship exemption certification described in paragraph (h)(2) of this section--

(i) For any month that includes a day on which the individual meets the requirements of 45 CFR 155.605(g)(3) or 45 CFR 155.605(g)(5);

(ii) For the months in 2014 prior to the individual's effective date of coverage, if the individual enrolls in a plan through an Exchange prior to the close of the open enrollment period for coverage in 2014; or

(iii) For any month that includes a day on which the individual meets the requirements of any other hardship for which:

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

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

* * * * *

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

§1.5000A-4 Computation of shared responsibility payment.

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

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

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John Dalrymple,

Deputy Commissioner for Services and Enforcement.