

of protection because the term “price election” is not applicable to all plans of insurance.

List of Subjects in 7 CFR Part 402

Crop insurance, Reporting and recordkeeping requirements.

Accordingly, as set forth in the preamble, the Federal Crop Insurance Corporation proposes to amend 7 CFR part 402 as follows:

PART 402—CATASTROPHIC RISK PROTECTION ENDORSEMENT

1. The authority citation for 7 CFR part 402 continues to read as follows:

Authority: 7 U.S.C. 1506(l), 1506(o).

2. Amend § 402.4 as follows:

a. Revise introductory text preceding section 1;

b. Remove the definitions in section 1 for “approved yield,” “county,” “expected market price,” “FSA,” “household,” “limited resource farmer,” “Secretary,” and “USDA;”

c. Revise section 2(a) introductory text;

d. Revise section 3(a);

e. Revise section 4(a);

f. Amend section 4(b) by removing the phrase “expected market price” and adding the phrase “price election” in its place;

g. Amend section 4(c) by removing the phrase “Actuarial Table or the Special Provisions” and adding the phrase “actuarial documents” in its place;

h. Remove section 4(d);

i. Amend section 6(b) introductory text by removing the phrase “Special Provisions” and adding the phrase “actuarial documents” in its place;

j. Amend section 6(b)(1) by removing the phrase “Special Provisions” and adding the phrase “actuarial documents” in its place;

k. Revise section 7; and

l. Amend section 9 by adding the phrase “, projected prices, dollar amounts of insurance, or dollar amounts of protection” after the phrase “multiple price elections” in the two instances that it appears.

The revised text reads as follows:

§ 402.4 Catastrophic Risk Protection Endorsement Provisions.

* * * * *

If a conflict exists among the policy provisions; the order of priority is: (1) This Endorsement; (2) the Special Provisions; (3) any other Actuarial Documents except the Special Provisions; (4) the Commodity Exchange Price Provisions, if applicable; and (5) any of the policies specified in section 2, with (1) controlling (2), etc.

* * * * *

2. Eligibility, Life of Policy, Cancellation, and Termination.

(a) You must have one of the following policies in force to elect this Endorsement:

(1) The Common Crop Insurance Policy Basic Provisions (7 CFR 457.8) and applicable Crop Provisions (Catastrophic risk protection coverage is not available under individual revenue plans of insurance such as the Revenue Protection and Revenue Protection with Harvest Price Exclusion plans of insurance);

(2) The Group Risk Plan of Insurance Basic Provisions (7 CFR 407.9) and applicable Crop Provisions, or its successor provisions, if available for catastrophic risk protection coverage (Catastrophic risk protection coverage is not available under area revenue plans of insurance such as Group Risk Income Protection—Harvest Price Option or Group Risk Income Protection plans of insurance or successor plans of insurance); or

(3) Other crop policy only if catastrophic risk protection coverage is provided in the applicable crop policy.

* * * * *

3. Unit Division.

(a) This section is in lieu of the unit provisions specified in the applicable crop policy and is not applicable if you are insured under the Group Risk Plan of Insurance Basic Provisions (7 CFR 407.9) and applicable Crop Provisions, or its successor provisions.

* * * * *

4. Insurance Guarantees, Coverage Levels, and Prices for Determining Indemnities.

(a) Unless otherwise specified in the actuarial documents, catastrophic risk protection coverage will offer protection equal to:

(1) Fifty percent (50%) of your approved yield indemnified at fifty-five percent (55%) of the price election or projected price, as applicable, if you are insured under the Common Crop Insurance Policy Basic Provisions (7 CFR 457.8) and applicable Crop Provisions;

(2) Sixty-five percent (65%) of the expected county yield indemnified at forty-five percent (45%) of the maximum protection per acre if you are insured under the Group Risk Plan of Insurance Basic Provisions (7 CFR 407.9) and applicable Crop Provisions, or its successor provisions; or

(3) A comparable coverage as established by FCIC for other crop policies only if catastrophic risk protection coverage is provided in the applicable crop policy.

* * * * *

7. Insured Crop.

(a) The crop insured is specified in the applicable crop policy, however notwithstanding any other policy provision requiring the same insurance coverage on all insurable acreage of the crop in the county, if you purchase additional coverage for a crop, you may separately insure acreage under catastrophic risk protection coverage that has been designated as “high-risk” land by FCIC, provided that you execute a High-Risk Land Exclusion Option and obtain a catastrophic risk protection coverage policy with the same approved insurance provider on or before the applicable sales closing date.

(b) You will be required to pay a separate administrative fee for both the additional coverage policy and the catastrophic risk protection coverage policy.

* * * * *

Signed in Washington, DC, on August 10, 2011.

William J. Murphy,
Manager, Federal Crop Insurance Corporation.

[FR Doc. 2011–20850 Filed 8–16–11; 8:45 am]

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–131491–10]

RIN 1545–BJ82

Health Insurance Premium Tax Credit

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 health insurance premium tax credit enacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended by the Medicare and Medicaid Extenders Act of 2010, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, and the Department of Defense and Full-Year Continuing Appropriations Act, 2011. These proposed regulations provide guidance to individuals who enroll in qualified health plans through Affordable Insurance Exchanges and claim the premium tax credit, and to Exchanges that make qualified health plans available to individuals and

employers. This document also provides notice of a public hearing on these proposed regulations.

DATES: Written (including electronic) comments must be received by October 31, 2011. Outlines of topics to be discussed at the public hearing scheduled for November 17, 2011, at 10 a.m. must be received by November 10, 2011.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG-131491-10), Room 5203, 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-131491-10), 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> (IRS REG-131491-10). 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, Shareen S. Pflanz, (202) 622-4920, or Frank W. Dunham III, (202) 622-4960; concerning the submission of comments, the public hearing, and to be placed on the building access list to attend the public hearing, Funmi Taylor, (202) 622-7180 (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 October 17, 2011. 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 properly reconcile the amount of the premium tax credit with advance credit payments made under section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082). The collection of information is required to comply with the provisions of section 36B(f)(3) of the Internal Revenue Code (Code). The likely respondents are Affordable Insurance Exchanges established under section 1311 or 1321 of the Patient Protection and Affordable Care Act (42 U.S.C. 13031 or 42 U.S.C. 18041).

The burden for the collection of information contained in proposed regulation § 1.36B-5 will be reflected in the burden on a form that the IRS will create to request the information in the proposed regulation.

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), individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges (Exchanges). Exchanges will offer Americans competition and choice. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs and Exchanges will give individuals and small businesses the same purchasing power as big businesses. The Departments of Health and Human Services and Treasury are working in close coordination to release guidance related to Exchanges, in several phases.

The first in this series was a Request for Comment relating to Exchanges, published in the **Federal Register** on August 3, 2010 (75 FR 45584). Second, Initial Guidance to States on Exchanges was issued on November 18, 2010. Third, proposed regulations on the application, review, and reporting process for waivers for State innovation was published in the **Federal Register** on March 14, 2011 (76 FR 13553). Fourth, two proposed regulations were published in the **Federal Register** on July 15, 2011 (76 FR 41866 and 76 FR 41930) to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act. Fifth, three proposed regulations, including this one, are being published in the **Federal Register** on August 17, 2011 to provide guidance on the eligibility determination process related to enrollment in a qualified health plan or insurance affordability program; on Medicaid, the Children's Health Insurance Program (CHIP), and other State health coverage programs; and these proposed regulations on the premium tax credit.

Section 1401 of the Affordable Care Act amended the Code to add section 36B, allowing a refundable premium tax credit to help individuals and families afford health insurance coverage. 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 section 36B credit is designed to make a qualified health plan affordable by reducing a taxpayer's out-of-pocket premium cost.

Under section 1411 of the Affordable Care Act (42 U.S.C. 18081), an Exchange makes an advance determination of credit eligibility for individuals enrolling in coverage through the Exchange and seeking financial assistance. Using information available at the time of enrollment, the Exchange determines (1) whether the individual meets the income and other requirements for advance credit payments, and (2) the amount of the advance payments. Advance payments are made monthly under section 1412 of the Affordable Care Act (42 U.S.C. 18082) to the issuer of the qualified health plan in which the individual enrolls.

Eligibility

To be eligible for a premium tax credit, an individual must be an applicable taxpayer. Under section 36B(c)(1), an applicable taxpayer is a taxpayer (1) With household income for the taxable year between 100 percent and 400 percent of the federal poverty line (FPL) for the taxpayer's family size, (2) who may not be claimed as a dependent by another taxpayer, and (3) who files a joint return if married.

Section 36B(c)(1)(B) provides that a taxpayer who is an alien lawfully present in the United States, whose household income is 100 percent of the FPL or less, and who is not eligible for Medicaid, nonetheless is treated as an applicable taxpayer. Under section 36B(e)(2), an individual is lawfully present if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit is claimed, a U.S. citizen or national or an alien lawfully present in the United States.

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. Section 152 provides that a taxpayer's dependent may be a qualifying child or qualifying relative, including an unrelated individual who lives with the taxpayer. Family size is equal to the number of individuals in the taxpayer's family.

Section 36B(d)(2) defines household income as the modified adjusted gross income of all individuals included in family size who are required to file an income tax return. Modified adjusted gross income means adjusted gross income (within the meaning of section 62) increased by amounts excluded from gross income under section 911 and tax-exempt interest a taxpayer receives or accrues during the taxable year.

Under section 36B(b)(1), a taxpayer's 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. Section 36B(c)(2)(A) provides that a coverage month is any month for which the taxpayer or any family member is covered by a qualified health plan enrolled in through an Exchange and the premium is paid by the taxpayer or through an advance credit payment.

Under section 36B(c)(2)(B), a coverage month for an individual does not include a month in which the individual is eligible for minimum essential coverage, as defined in section

5000A(f), other than coverage offered in the individual market. Minimum essential coverage may be government-sponsored coverage such as Medicare, Medicaid, CHIP, TRICARE, and veterans' health care under Title 38 U.S.C. Certain employer-sponsored plans also may be minimum essential coverage. In general, under section 36B(c)(2)(C), an individual is eligible for employer-sponsored minimum essential coverage only if the employee's share of the premiums is affordable and the coverage provides minimum value. However, under section 36B(c)(2)(C)(iii), an individual is treated as eligible for employer-sponsored minimum essential coverage if the individual actually enrolls in an eligible employer-sponsored plan, even if the coverage does not meet the affordability and minimum value requirements.

Under section 5000A(f)(1)(E), the Department of Health and Human Services, in coordination with the Treasury Department, may designate other health benefits coverage as minimum essential coverage. Regulations under section 5000A are expected to provide additional guidance on minimum essential coverage.

Credit Computation

Section 36B(b)(1) provides 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, 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))) (the benchmark plan) that applies to the taxpayer over $\frac{1}{12}$ of the product of the taxpayer's household income and the applicable percentage for the taxable year. The adjusted monthly premium, in general, is the premium an insurer would charge for the plan adjusted only for the ages of the covered individuals.

Therefore, the monthly premium assistance amount is the lesser of the premium for the qualified health plan in which a taxpayer or family member enrolls, or the excess of the premium for the benchmark plan over the applicable percentage of the taxpayer's household income. In general, this percentage of the taxpayer's household income represents the amount of the taxpayer's required out-of-pocket contribution to the premium cost if the taxpayer purchases the benchmark plan. The

remainder of the premium for the benchmark plan is the premium assistance amount.

A taxpayer's applicable percentage increases as the taxpayer's household income as a percentage of the FPL (FPL percentage) for the taxpayer's family size increases. For 2014, the applicable percentage is 2 percent for taxpayers with household income up to 133 percent of the FPL and increases from 3 percent to 9.5 percent for taxpayers with household incomes between 133 percent and 400 percent of the FPL. The applicable percentages may be adjusted after 2014.

Taxpayers must pay the difference between the premium assistance amount and the premium for the plan they choose. The amount of a taxpayer's credit is limited to the amount of actual premiums for the taxable year.

Individuals not lawfully present are not eligible to enroll in a qualified health plan through an Exchange. Accordingly, section 36B(e)(1)(A) provides that, for a household with at least one individual not lawfully present, the portion (if any) of the premium attributable to that individual is not included in determining the taxpayer's credit. Section 36B(e)(1)(B) provides that the family size for computing the FPL percentage for a family with at least one unlawfully present individual is determined by excluding the unlawfully present individual. Household income for computing the FPL percentage and determining the applicable percentage is the product of the taxpayer's household income (determined without regard to section 36B(e)) and a fraction, the numerator of which is the FPL for the taxpayer's family size excluding individuals who are not lawfully present, and the denominator of which is the FPL for the taxpayer's family size including individuals who are not lawfully present.

Reconciliation

A taxpayer must reconcile the actual credit for the taxable year computed on the taxpayer's tax return with the amount of advance payments. If a taxpayer's credit amount exceeds the amount of the taxpayer's advance payments for the taxable year, the taxpayer may receive the excess as an income tax refund. If a taxpayer's advance payments exceed the taxpayer's credit amount, the taxpayer owes the excess as an additional income tax liability. However, section 36B(f)(2)(B) places a graduated set of caps on the additional tax liability for taxpayers with household income under 400 percent of the FPL. The repayment

limitation amounts range from \$600 to \$2,500 (one-half that amount for single taxpayers) depending on FPL, and are adjusted to reflect changes in the cost of living beginning in 2015.

Section 36B(g) directs the Secretary of the Treasury to issue regulations that provide for coordinating the premium tax credit with the program for advance payments and for reconciling the credit and advance payments when the taxpayer's filing status changes during the taxable year.

Information Reporting

Section 36B(f)(3) directs an Exchange to report to the IRS and taxpayers certain information relating to health plans provided through the Exchange, including the amount of any advance credit payments.

Explanation of Provisions

1. Eligibility for the Premium Tax Credit

The proposed regulations provide that a taxpayer is eligible for the credit for a taxable year if the taxpayer is an applicable taxpayer and the taxpayer or a member of the taxpayer's family (1) is enrolled in one or more qualified health plans through an Exchange established under section 1311 or 1321 of the Affordable Care Act (42 U.S.C. 13031 or 42 U.S.C. 18041) and (2) is not eligible for minimum essential coverage other than coverage in the individual market.

a. Applicable Taxpayer

i. Lawfully Present Aliens

In general, to be an applicable taxpayer, a taxpayer must have household income that is at least 100 percent but not more than 400 percent of the FPL. Under section 36B(c)(1)(B), a lawfully present alien with household income under 100 percent of the FPL and not eligible for Medicaid is treated as having household income of 100 percent of the FPL for purposes of qualifying as an applicable taxpayer. The proposed regulations provide that premium assistance amounts for these taxpayers are computed based on actual household income. The proposed regulations define lawfully present by reference to 45 CFR 152.2, which determines lawful presence for purposes of the Pre-Existing Condition Insurance Plan Program.

ii. Taxpayers With Household Income Under 100 Percent of the FPL

The proposed regulations clarify the treatment of a taxpayer who receives advance credit payments but has household income below 100 percent of the FPL for the taxable year.

Taxpayers with household incomes below 100 percent of the FPL (other than lawfully present aliens) are not eligible for the premium tax credit because they are eligible to receive assistance through Medicaid. However, an Exchange may approve a taxpayer for advance credit payments based on projecting a level of household income for the taxable year that makes the taxpayer ineligible for Medicaid. If, contrary to that projection, the taxpayer's actual household income for the taxable year is under 100 percent of the FPL (for example, because the taxpayer experiences a change in circumstances, such as a job loss, during the year), the taxpayer would not be an applicable taxpayer, and would not be eligible for the credit under the general rule. Accordingly, the proposed regulations provide a special rule treating a taxpayer with household income below 100 percent of the FPL as an applicable taxpayer if, when a taxpayer enrolls in a qualified health plan, an Exchange projects that household income for the taxpayer will be between 100 and 400 percent of the FPL for the taxable year and approves advance credit payments. Premium assistance amounts for these taxpayers also are computed based on actual household income and not a deemed household income that equals 100 percent of the FPL.

iii. Individuals Who Are Incarcerated or Not Lawfully Present

Under section 1312(f) of the Affordable Care Act, individuals who are incarcerated (other than pending disposition of charges) or not lawfully present in the United States may not enroll in a qualified health plan through an Exchange. However, these individuals may have family members who are eligible for Exchange coverage. Accordingly, the proposed regulations provide that an individual who is not lawfully present in the United States or is incarcerated, although not eligible to enroll in a qualified health plan, may be an applicable taxpayer if a family member is eligible to and does enroll in a qualified health plan.

b. Minimum Essential Coverage

i. Government-Sponsored Coverage

Under the proposed regulations, an individual generally is eligible for government-sponsored minimum essential coverage for any month that the individual meets the requirements for coverage under a government-sponsored program described in section 5000A(f)(1)(A). However, for purposes of the premium tax credit, an individual

is eligible for minimum essential coverage under a veterans' health care program only if the individual is enrolled in a veteran's health care program identified as minimum essential coverage in regulations issued under section 5000A. The Commissioner may define eligibility for specific government-sponsored programs further in published guidance of general applicability, see § 601.601(d)(2) of this chapter. For example, it is expected that future guidance will provide that a person is eligible for Medicaid on the basis of being blind or disabled or needing long-term care services only when a State Medicaid agency or the Social Security Administration, as appropriate, determines that the individual is blind or disabled or requires long-term care services.

In general, an individual is treated as eligible for a government-sponsored program on the first day of the first full month in which the individual may receive benefits. Thus, taxpayers would not lose eligibility for the credit for a month in which the taxpayer or a family member is technically eligible for a government program but cannot yet receive benefits due to, for example, the need for administrative processing. However, an individual who fails to complete the requirements to obtain coverage available under a government-sponsored program (other than coverage under the veteran's health care program) reasonably promptly is treated as eligible for the coverage on the first day of the second calendar month following the event that establishes eligibility (such as reaching age 65 for Medicare).

An individual receiving advance credit payments may apply and be approved for government-sponsored minimum essential coverage such as Medicaid that, after approval, is effective retroactively (overlapping some advance payment coverage months). The proposed regulations provide that an individual in this situation is treated as eligible for minimum essential coverage no sooner than the first day of the first calendar month after the approval.

Comments are requested on whether rules should provide additional flexibility if operational challenges prevent timely transition from coverage under a qualified health plan to coverage under a government-sponsored program.

A taxpayer whom an Exchange has determined to be ineligible for Medicaid, CHIP, or a similar program at the time of enrollment may end up with household income for the taxable year within the eligibility criteria for these

programs. Therefore, the proposed regulations provide that an individual is treated as not eligible for Medicaid, CHIP, or a similar program for the months of coverage under a qualified health plan if an Exchange determines that the individual is not eligible when the individual enrolls. If the individual subsequently enrolls in Medicaid, CHIP, or a similar program, however, the full months of enrollment in the government-sponsored coverage are not coverage months.

ii. Employer-Sponsored Coverage

A. In General

Section 5000A(f)(1)(B) provides that minimum essential coverage includes coverage under an eligible employer-sponsored plan. Under section 5000A(f)(2), an eligible employer-sponsored plan is a group health plan or group health insurance coverage offered by an employer to an employee that is a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act (42 U.S.C. 300gg–91(d)(8))), any other plan or coverage offered in the small or large group market, or a grandfathered plan offered in the group market. Regulations under section 5000A are expected to provide that an employer-sponsored plan will not fail to be minimum essential coverage solely because it is a plan to reimburse employees for medical care for which reimbursement is not provided under a policy of accident and health insurance (a self-insured plan).

Continuation coverage required under federal law or required under a state law that provides comparable continuation coverage is eligible employer-sponsored coverage. The proposed regulations provide a special rule that an individual eligible to enroll in continuation coverage is eligible for minimum essential coverage only if the individual enrolls in the coverage.

The proposed regulations provide that an individual generally is eligible for minimum essential coverage through an eligible employer-sponsored plan for a month during a plan year if the individual had the opportunity to enroll in the plan, even if the enrollment period has since closed. Thus, once an individual fails to enroll in eligible employer-sponsored coverage during an employer-sponsored plan's enrollment period after having had the opportunity to do so (assuming the coverage is affordable and provides minimum value), the months during the plan year are not coverage months for the individual, notwithstanding that the individual is precluded from later

enrolling in the employer-sponsored coverage for those months because the enrollment period has expired.

Under section 36B(c)(2)(C), an individual generally is eligible for employer-sponsored minimum essential coverage only if the employee's share of the premiums is affordable and the coverage provides minimum value. An individual is treated as eligible for minimum essential coverage through an eligible employer-sponsored plan, however, if the individual actually enrolls in the coverage, including coverage that does not meet the requirements for affordability and minimum value.

B. Affordability of Employer-Sponsored Coverage

Section 36B(c)(2)(C)(i) prescribes the standards for determining whether employer-sponsored coverage is affordable for an employee as well as for other individuals. In the case of an employee, under section 36B(c)(2)(C)(i), an employer-sponsored plan is not affordable if "the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income" for the taxable year. This percentage may be adjusted after 2014.¹

In the case of an individual other than an employee, section 36B(c)(2)(C)(i) provides that "this clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee." The cross-referenced section 5000A(e)(1)(B) defines the term "required contribution" for this purpose as "the portion of the annual premium which would be paid by the individual * * * for self-only coverage."

Thus, the statutory language specifies that for both employees and others (such as spouses or dependents) who are eligible to enroll in employer-sponsored coverage by reason of their relationship to an employee (related individuals), the coverage is unaffordable if the required contribution for "self-only" coverage (as opposed to family coverage or other coverage applicable to multiple individuals)

¹ In addition, the statute provides for the Comptroller General, within 5 years of enactment, to conduct a study, including legislative recommendations, on the affordability of coverage, including whether the percentage of household income specified in section 36B(c)(2)(C) "is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage." See section 1401(c)(1) of the Affordable Care Act.

exceeds 9.5 percent of household income. See Joint Committee on Taxation, General Explanation of Tax Legislation Enacted in the 111th Congress, JCS–2–11 (March 2011) at 265 (stating that, for purposes of the premium tax credit provisions of the Act, "[u]naffordable is defined as coverage with a premium required to be paid by the employee that is more than 9.5 percent of the employee's household income, based on the self-only coverage").

Consistent with these statutory provisions, the proposed regulations provide that an employer-sponsored plan also is affordable for a related individual for purposes of section 36B if the employee's required contribution for self-only coverage under the plan does not exceed 9.5 percent of the applicable taxpayer's household income for the taxable year, even if the employee's required contribution for the family coverage does exceed 9.5 percent of the applicable taxpayer's household income for the year.

Although the affordability test for related individuals for purposes of the premium tax credit is based on the cost of self-only coverage, future proposed regulations under section 5000A are expected to provide that the affordability test for purposes of applying the individual responsibility requirement to related individuals is based on the employee's required contribution for employer-sponsored family coverage. Section 5000A addresses affordability for employees in section 5000A(e)(1)(B) and, separately, for related individuals in section 5000A(e)(1)(C).

C. Employee Affordability Safe Harbor

The proposed regulations provide an employee safe harbor for individuals who were offered eligible employer-sponsored coverage that ultimately proves to be affordable based on household income for the taxable year but who declined the offer because, at the time of enrollment in a qualified health plan, the Exchange determined that the employer coverage would be unaffordable. Under the safe harbor, an eligible employer-sponsored plan is treated as unaffordable for an entire plan year. Thus, for the months during the plan year (which may coincide or overlap with the taxable year) a taxpayer will not lose credit eligibility because, as a result of changes during the taxable year, the employer coverage would have been affordable based on the household income for that taxable year. The taxpayer may, however, lose credit eligibility for other reasons, for example if the taxpayer's household income for

the taxable year exceeds 400 percent of the FPL. Regulations under section 4980H are expected to provide that an employer is not subject to a penalty merely because an employee receives a premium tax credit under this employee safe harbor if the employer offered to its employees affordable coverage that otherwise meets the requirements of section 4980H.

D. Affordability Safe Harbor for Employers

In general, an applicable large employer (as defined in section 4980H(c)(2)) that offers health coverage to its full-time employees and their dependents is subject to the assessable payment under section 4980H(b) if at least one full-time employee is certified to receive a premium tax credit or cost-sharing reduction because the employer-sponsored coverage either does not provide minimum value or is unaffordable to the employee.

Employers have commented that they will not know their employees' actual household income. As a result, even if an employer intends to offer affordable coverage to all full-time employees, one or more full-time employees may be certified to receive the premium tax credit, and the employer may be subject to the assessable payment under 4980H(b). Future proposed regulations under section 4980H are expected to provide an affordability safe harbor for employers. Under this anticipated safe harbor, an employer that meets certain requirements, including offering its full-time employees (and their dependents) the opportunity to enroll in eligible employer-sponsored coverage, will not be subject to an assessable payment under section 4980H(b) with respect to an employee who receives a premium tax credit or cost-sharing reduction for a taxable year if the employee portion of the self-only premium for the employer's lowest cost plan that provides minimum value does not exceed 9.5 percent of the employee's current W-2 wages from the employer.

Giving employers the ability to base their affordability calculations on their employees' wages (which employers know) instead of employees' household income (which employers generally do not know) is intended to provide a more workable and predictable method of facilitating affordable employer-sponsored coverage for the benefit of both employers and employees. Notwithstanding this safe harbor, employees' eligibility for a premium tax credit would continue to be based on affordability of employer-sponsored coverage relative to employees' household income. Accordingly, some

employees—among the small percentage of employees whose household income is less than their wages from the employer—would receive a premium tax credit without resulting in an assessable payment by their employer. The Treasury Department and the IRS intend to issue a request for comments on this affordability safe harbor for employers.

E. Minimum Value

Section 36B(c)(2)(C)(ii) provides that an eligible employer-sponsored plan generally provides minimum value if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of those costs. Under section 1302(d)(2) of the Affordable Care Act (42 U.S.C. 18022(d)(2)), regulations to be issued by the Secretary of Health and Human Services will apply in determining the percentage of "the total allowed costs of benefits" provided under a group health plan or health insurance coverage that are covered by that plan or coverage. The regulations under section 1302(d)(2) are expected to be proposed later this year and to reflect the fact that employer-sponsored group health plans and health insurance coverage in the large group market are not required to provide each of the essential health benefits or each of the 10 categories of benefits described in section 1302(b)(1) of the Affordable Care Act. It is also anticipated that the regulations will seek to further the objective of preserving the existing system of employer-sponsored coverage, but without permitting the statutory employer responsibility standards to be avoided. We also are contemplating whether to provide appropriate transition relief with respect to the minimum value requirement for employers currently offering health care coverage.

2. Computing the Premium Tax Credit

A taxpayer's credit is the sum of the premium assistance amounts for each coverage month in the taxable year. A premium assistance amount is computed for each coverage month during the taxable year based on several factors: household income, family size, applicable percentage, benchmark plan premium, and actual plan premium. A month during which no one in the taxpayer's family is enrolled in a qualified health plan through an Exchange is not a coverage month. A month is a coverage month only if the taxpayer pays the premium for coverage or receives the benefit of an advance payment. The premium assistance amount for a month that is not a

coverage month is zero. Household income is determined on an annual basis and is prorated for each month to determine the monthly premium assistance amount. The applicable percentage is the same for each month because it is derived from annual household income and family size. A taxpayer's benchmark plan premium may change during the year if, for example, there are changes in the members of the household covered through the Exchange or the taxpayer moves to a new State with different plan rates.

a. Premiums Paid on Behalf of the Taxpayer

The proposed regulations provide that, in determining whether a month is a coverage month, premiums that another person pays for the coverage of the taxpayer or a family member are treated as paid by the taxpayer.

b. Applicable Benchmark Plan

Under section 36B(b)(2), the monthly premium for the applicable second lowest cost silver plan offered through an Exchange is the benchmark for computing a taxpayer's monthly premium assistance amount. To determine the amount of premium tax credit, a taxpayer must compute the difference between the premium for this plan and the applicable percentage of the taxpayer's household income, regardless of the qualified health plan the taxpayer purchases.

i. Multiple Categories of Coverage Offered on an Exchange

Section 36B(b)(3)(B)(ii) identifies only self-only and family as the categories of coverage for the benchmark plan. However, qualified health plans may offer other categories of coverage based on family composition, such as children only, two adults, or one adult plus children. See proposed 45 CFR 156.255(b). Thus, the proposed regulations define family coverage as any health insurance that covers more than one individual.

Under the proposed regulations, the "applicable" benchmark plan for a taxpayer is determined by finding the second lowest cost plan at the silver level that would cover those family members actually enrolled in a qualified health plan, not eligible for minimum essential coverage other than coverage in the individual market, not incarcerated, and lawfully present in the United States (the coverage family). Thus, the applicable benchmark plan is the self-only category of coverage for a taxpayer who files as single with no dependents, a taxpayer who purchases

self-only coverage, and a taxpayer whose family includes only one individual who is not eligible for minimum essential coverage or one lawfully present individual (thus excluding from the credit computation the portion of the premium attributable to an individual not lawfully present, as required by section 36B(e)(1)(A)). If an Exchange offers more categories of coverage than self-only and family, the applicable benchmark plan is the coverage category that applies to the members of the taxpayer's coverage family.

ii. Families Who Purchase More Than One Qualified Health Plan

Section 36B determines family size by reference to individuals for whom the taxpayer claims a personal exemption, and family coverage under some qualified health plans may not extend to certain tax dependents (for example, a niece). We note that the Department of Health and Human Services has requested comments in its proposed regulations on Exchanges on whether qualified health plans offered on an Exchange should be required to cover all members of the family if they live in the same Exchange service area. Pending the issuance of additional guidance on this issue by Health and Human Services, the proposed regulations provide that, if the applicable benchmark plan does not cover a taxpayer's full family, the applicable benchmark plan premium for these families is the sum of the premiums for the benchmark plans that cover the taxpayer's family (for example, for an uncle and two adult dependent nieces, a self-only benchmark plan for the uncle and a two-adult or family plan for the nieces). The applicable benchmark plan is similarly modified for taxpayers with family members residing in different rating areas (also known as Exchange service areas, see proposed 45 CFR 155.20). However, the IRS and Treasury Department are considering other approaches for determining the applicable benchmark plan in these cases. For example, the applicable benchmark plan for these families could be the benchmark plan that would apply to the family composition (such as one adult plus children) if one plan covered all members of the taxpayer's family. Alternatively, the applicable benchmark plan premium could be the lesser of (1) the premium for a combination of plans that cover the taxpayer's entire family, or (2) the premium for a single plan that covers the taxpayer's entire family and is more expensive than the second lowest cost silver plan. Comments are

requested on these and other possible approaches.

iii. One Qualified Health Plan Covering More Than One Family

If a single qualified health plan covers more than one taxpayer's family (for example a plan that covers adult children under age 26 who are not tax dependents), the allowable section 36B credit is computed for each applicable taxpayer covered by the plan. An individual applicable percentage is determined for each taxpayer based on the taxpayer's household income and family size, and the separate applicable benchmark plan. The premiums for the qualified health plan the taxpayers purchase are allocated to each taxpayer in proportion to the premiums for each taxpayer's benchmark plan to determine whether the premiums paid are less than the benchmark premium minus the taxpayer's applicable percentage of household income.

iv. Applicable Benchmark Plan That Terminates or Closes to Enrollment

A qualified health plan that is the second lowest cost silver plan for a particular category of coverage, or the lowest cost silver plan in that category, may close to enrollment or terminate during the taxable year. The proposed regulations clarify that an applicable benchmark plan is a plan offered through the Exchange when a taxpayer or family member enrolls in a qualified health plan. Unless the taxpayer or a family member is enrolled in the applicable benchmark plan, a plan does not cease to be the applicable benchmark plan solely because the plan or the lowest cost silver plan terminates or closes to further enrollment during the taxable year.

c. Pediatric Dental Coverage

Section 36B(b)(3)(E) provides that, for purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan providing dental coverage as described in section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)), the portion of the premium for the dental plan that is properly allocable to pediatric dental benefits that are essential health benefits is treated as a premium payable for the individual's qualified health plan. Thus, the portion of the premium for the separate pediatric dental coverage is added to the premium for the benchmark plan in computing the credit. Comments are requested on methods of determining the amount of the premium properly allocable to pediatric dental benefits.

3. Reconciling the Credit and Advance Credit Payments

The proposed regulations describe the requirements for reconciling advance payments of the credit with the actual credit amount and determining the amount of any resulting additional credit or additional income tax liability. The proposed regulations explain that the credit is computed by using the household income and family size for the taxable year, but premium assistance amounts for different coverage months may be based on different applicable benchmark plans if, for example, the taxpayer's family composition changes during the taxable year.

a. Changes in Filing Status

Section 36B(g)(2) directs the Secretary to provide regulations specifying how to reconcile advance payments with the actual credit when the taxpayer's filing status on the return claiming the credit differs from the filing status used to determine advance payments of the credit. Filing status may be any of the following: single, married filing jointly, married filing separately, head of household, or surviving spouse.

i. Computing the Credit When Taxpayer's Marital Status Changes

The proposed regulations provide that, for a taxpayer who has a change in marital status during the taxable year, the credit generally is computed according to the same rules that apply to other taxpayers, using the applicable benchmark plan or plans that apply to the taxpayer's marital status as of the first day of each month. However, the proposed regulations include special rules for computing the credit for taxpayers who divorce during the taxable year. Comments are requested on special rules for taxpayers who marry during the taxable year and for married taxpayers who face challenges in being able to file a joint return.

ii. Taxpayers Who Divorce During the Taxable Year

The proposed regulations provide that, for purposes of reconciliation, taxpayers who for some months during a taxable year were married (within the meaning of section 7703) and were covered by the same qualified health plan but are no longer married on the last day of the taxable year, may agree to allocate between themselves, in the same proportion, the premiums for the benchmark plan, premiums paid and advance credit payments made during the marriage. If the taxpayers do not agree on an allocation, the taxpayers must allocate 50 percent of these amounts to each taxpayer. If only one of

the formerly married taxpayers was enrolled in the plan, 100 percent of the benchmark premiums, premiums for the plan that taxpayer purchases, and advance payments are allocated to that taxpayer.

iii. Taxpayers Who Marry During the Taxable Year

For individuals who marry during a taxable year and receive advance credit payments during the time before they are married, the general rules for credit computation and reconciliation could lead to the individuals facing additional tax upon reconciliation, even if the Exchange accurately determines each individual's separate income for the year at the time of enrollment. This may occur, for example, in situations in which the combination of two individuals' household incomes and families results in the combined family having a higher FPL percentage than either of the component families would have had if the individuals had not married, and therefore having a higher applicable percentage or being ineligible for a credit. Comments are requested on rules providing relief to certain individuals who would owe additional tax because they marry during a taxable year when one or both individuals receive advance credit payments prior to marriage. Comments are requested on how the premium assistance credit amount should be computed in this circumstance, including how household income (which is required to be determined on an annual basis) and dependents for the taxable year would be taken into account in the credit computation.

iv. Married Taxpayers Filing Separately

Married taxpayers who file their returns as married filing separately are not applicable taxpayers and generally are ineligible for the premium tax credit for any month during the taxable year. The proposed regulations provide that taxpayers who receive advance credit payments and file their tax returns as married filing separately must allocate 50 percent of any advance credit payments to each spouse for purposes of determining their excess advance payment amounts as part of the reconciliation process. Although the taxpayers owe additional tax for the entire amount of the advance credit payments, the section 36B(f)(2)(B) repayment limitation applies to each taxpayer whose household income is below 400 percent of the federal poverty line based on the household income and family size reported on the return.

Some taxpayers who are married at the time they enroll in a qualified health

plan and begin to receive advance credit payments may not be able to file a joint return for the coverage year. For example, in situations involving domestic abuse, when a divorce is pending but not yet final, or when one spouse is incarcerated, filing a joint return may not be possible or prudent. Comments are requested on rules to provide relief for those married taxpayers who have received advance credit payments but face challenges in being able to file a joint return. Comments are requested in particular on whether rules should take into account whether (1) The spouses have filed jointly for the preceding taxable year, (2) the spouses attested to an expectation to file jointly for purposes of receiving the advance credit payments, and (3) the spouses should be allowed relief of this type for more than one year.

Comments are requested on other rules for reconciling the credit with advance payments for taxpayers whose filing status changes during the taxable year.

b. Requirement To File a Return

The proposed regulations require every taxpayer receiving advance credit payments to file an income tax return on or before the fifteenth day of the fourth month following the close of the taxable year. The requirement to file a return applies whether or not a taxpayer is otherwise required to file a return under section 6012 or claims a premium tax credit for the taxable year. Under section 6081, the Commissioner may grant a reasonable extension of time for filing any income tax return.

Effective/Applicability Date

These regulations are proposed to apply for taxable years ending 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 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, and, because the regulations do not impose a collection of information requirement on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the 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 Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (either electronic or a signed paper original and eight (8) copies) that are submitted timely to the IRS. The IRS and Treasury Department request comments on the clarity of the proposed rules and how they can be made easier to understand. All comments will be available for public inspection and copying.

A public hearing has been scheduled for November 17, 2011, 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. All visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance 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 written comments (electronic or a signed paper original and eight (8) copies) and an outline of topics to be discussed and the time devoted to each topic by November 10, 2011. 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 these proposed regulations are Shareen S. Pflanz, Frank W. Dunham III, 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 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 is amended by adding entries in numerical order to read in part as follows:

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

Section 1.36B-4 also issued under 26 U.S.C. 36B(g).

Par. 2. Sections 1.36B-0, 1.36B-1, 1.36B-2, 1.36B-3, 1.36B-4, and 1.36B-5 are added to read as follows:

§ 1.36B-0 Table of contents.

This section lists the captions contained in §§ 1.36B-1 through 1.36B-5.

§ 1.36B-1 Premium tax credit definitions.

- (a) In general.
- (b) Affordable Care Act.
- (c) Qualified health plan.
- (d) Family and family size.
- (e) Household income.
 - (1) In general.
 - (2) Modified adjusted gross income.
- (f) Dependent.
- (g) Lawfully present.
- (h) Federal poverty line.
- (i) Reserved.
- (j) Advance credit payment.
- (k) Exchange.
- (l) Self-only coverage.
- (m) Family coverage.
- (n) Rating area.
- (o) Effective/applicability date.

§ 1.36B-2 Eligibility for premium tax credit.

- (a) In general.
- (b) Applicable taxpayer.
 - (1) In general.
 - (2) Married taxpayers must file joint return.
 - (3) Dependents.
 - (4) Individuals not lawfully present or incarcerated.
 - (5) Individuals lawfully present.
 - (6) Special rule for taxpayers with household income below 100 percent of the federal poverty line for the taxable year.
 - (7) Computation of premium assistance amounts for taxpayers with household income below 100 percent of the federal poverty line.
 - (c) Minimum essential coverage.
 - (1) In general.
 - (2) Government-sponsored minimum essential coverage.
 - (i) In general.
 - (ii) Special rule for coverage under the veteran's health care program under chapter 17 or 18 of Title 38, U.S.C.

- (iii) Time of eligibility.
 - (A) In general.
 - (B) Retroactive effect of eligibility determination.
 - (iv) Determination of Medicaid or Children's Health Insurance Program (CHIP) ineligibility.
 - (v) Examples.
 - (3) Employer-sponsored minimum essential coverage.
 - (i) In general.
 - (ii) Plan year.
 - (iii) Eligibility for coverage months during a plan year.
 - (A) In general.
 - (B) Example.
 - (iv) Special rule for continuation coverage.
 - (v) Affordable coverage.
 - (A) In general.
 - (1) Affordability.
 - (2) Employee safe harbor.
 - (B) Required contribution percentage.
 - (C) Examples.
 - (vi) Minimum value.
 - (vii) Enrollment in eligible employer-sponsored plan.
 - (A) In general.
 - (B) Example.

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

- (a) In general.
- (b) Definitions.
- (c) Coverage month.
 - (1) In general.
 - (2) Premiums paid for the taxpayer.
- (3) Examples.
- (d) Premium assistance amount.
- (e) Adjusted monthly premium.
- (f) Applicable benchmark plan.
 - (1) In general.
 - (2) Family coverage.
 - (3) Second lowest cost silver plan not covering the taxpayer's family.
 - (4) Benchmark plan terminates or closes to enrollment.
 - (5) Examples.
 - (g) Applicable percentage.
 - (1) In general.
 - (2) Applicable percentage table.
 - (3) Examples.
 - (h) Plan covering more than one family.
 - (1) In general.
 - (2) Example.
 - (i) Reserved.
 - (j) Additional benefits.
 - (1) In general.
 - (2) Method of allocation.
 - (k) Pediatric dental coverage.
 - (1) In general.
 - (2) Method of allocation.
 - (l) Families including individuals not lawfully present.
 - (1) In general.
 - (2) Revised household income computation.
 - (i) Statutory method.

- (ii) Comparable method.

§ 1.36B-4 Reconciling the premium tax credit with advance credit payments.

- (a) Reconciliation.
 - (1) In general.
 - (2) Credit computation.
 - (3) Limitation on additional tax.
 - (i) In general.
 - (ii) Additional tax limitation table.
 - (4) Examples.
 - (b) Changes in filing status.
 - (1) In general.
 - (2) Taxpayers not married to each other at the end of the taxable year.
 - (3) Married taxpayers filing separate returns.
 - (4) Examples.

§ 1.36B-5 Information reporting by Exchanges.

- (a) Information required to be reported.
- (b) Time and manner of reporting.

§ 1.36B-1 Premium tax credit definitions.

(a) *In general.* Section 36B allows a refundable premium tax credit for taxable years ending after December 31, 2013. The definitions in this section apply to this section and §§ 1.36B-2 through 1.36B-5.

(b) *Affordable Care Act.* The term *Affordable Care Act* refers to 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)), as 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)).

(c) *Qualified health plan.* The term *qualified health plan* has the same meaning as in section 1301(a) of the Affordable Care Act (42 U.S.C. 18021(a)) but does not include a catastrophic plan described in section 1302(e) of the Affordable Care Act (42 U.S.C. 18022(e)).

(d) *Family and family size.* A taxpayer's family means the individuals for whom a taxpayer properly claims a deduction for a personal exemption under section 151 for the taxable year. Family size means the number of individuals in the family. Family and family size include an individual who is exempt from the requirement to maintain minimum essential coverage under section 5000A.

(e) *Household income*—(1) *In general.* Household income means the sum of—

(i) A taxpayer's modified adjusted gross income; plus

(ii) The aggregate modified adjusted gross income of all other individuals who—

(A) Are included in the taxpayer's family under paragraph (d) of this section; and

(B) Are required to file an income tax return for the taxable year (determined without regard to the exception under section (1)(g)(7) to the requirement to file a return).

(2) *Modified adjusted gross income.* Modified adjusted gross income means adjusted gross income (within the meaning of section 62) increased by amounts excluded from gross income under section 911 and tax-exempt interest the taxpayer receives or accrues during the taxable year.

(f) *Dependent.* Dependent has the same meaning as in section 152.

(g) *Lawfully present.* Lawfully present has the same meaning as in 45 CFR 152.2.

(h) *Federal poverty line.* The federal poverty line means the most recently published poverty guidelines (updated periodically in the **Federal Register** by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2)) as of the first day of the regular enrollment period for coverage by a qualified health plan offered through an Exchange for a calendar year. Thus, the federal poverty line for computing the premium tax credit for a taxable year is the federal poverty line in effect on the first day of the initial or annual open enrollment period preceding that taxable year. See 45 CFR 155.410.

(i) [Reserved]

(j) *Advance credit payment.* Advance credit payment means an advance payment of the premium tax credit as provided in section 1412 of the Affordable Care Act (42 U.S.C. 18082).

(k) *Exchange.* Exchange has the same meaning as in 45 CFR 155.20.

(l) *Self-only coverage.* Self-only coverage means health insurance that covers one individual.

(m) *Family coverage.* Family coverage means health insurance that covers more than one individual.

(n) *Rating area.* Rating area means an Exchange service area, as described in 45 CFR 155.20.

(o) *Effective/applicability date.* This section and §§ 1.36B–2 through 1.36B–5 apply for taxable years ending after December 31, 2013.

§ 1.36B–2 Eligibility for premium tax credit.

(a) *In general.* An applicable taxpayer (within the meaning of paragraph (b) of this section) is allowed a premium assistance amount only for any month that the applicable taxpayer, or the applicable taxpayer's spouse or dependent—

(1) Is enrolled in one or more qualified health plans through an Exchange; and

(2) Is not eligible for minimum essential coverage (within the meaning of paragraph (c) of this section) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(b) *Applicable taxpayer*—(1) *In general.* Except as otherwise provided in this paragraph (b), an applicable taxpayer is a taxpayer whose household income is at least 100 percent but not more than 400 percent of the federal poverty line for the taxpayer's family size for the taxable year.

(2) *Married taxpayers must file joint return.* A taxpayer who is married (within the meaning of section 7703) at the close of the taxable year is an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(3) *Dependents.* An individual is not an applicable taxpayer if another taxpayer may claim a deduction under section 151 for the individual for a taxable year beginning in the calendar year in which the individual's taxable year begins.

(4) *Individuals not lawfully present or incarcerated.* An individual who is not lawfully present in the United States or is incarcerated (other than incarceration pending disposition of charges) may not be covered by a qualified health plan through an Exchange. However, the individual may be an applicable taxpayer if a family member is eligible to enroll in a qualified health plan. See sections 1312(f)(1)(B) and 1312(f)(3) of the Affordable Care Act (42 U.S.C. 18032(f)(1)(B) and (f)(3)) and § 1.36B–3(b)(2).

(5) *Individuals lawfully present.* If a taxpayer's household income is less than 100 percent of the federal poverty line for the taxpayer's family size and the taxpayer or a member of the taxpayer's family is an alien lawfully present in the United States, the taxpayer is treated as an applicable taxpayer if—

(i) The taxpayer or family member is not eligible for the Medicaid program; and

(ii) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year

was between 100 and 400 percent of the federal poverty line for the taxpayer's family size.

(6) *Special rule for taxpayers with household income below 100 percent of the federal poverty line for the taxable year.* 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 if—

(i) The taxpayer or a family member enrolls in a qualified health plan through an Exchange;

(ii) An Exchange estimates at the time of enrollment that the taxpayer's household income will be between 100 and 400 percent of the federal poverty line for the taxable year;

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

(iv) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was between 100 and 400 percent of the federal poverty line for the taxpayer's family size.

(7) *Computation of premium assistance amounts for taxpayers with household income below 100 percent of the federal poverty line.* If a taxpayer is treated as an applicable taxpayer under paragraph (b)(5) or (b)(6) of this section, the taxpayer's actual household income for the taxable year is used to compute the premium assistance amounts under § 1.36B–3(d).

(c) *Minimum essential coverage*—(1) *In general.* Minimum essential coverage is defined in section 5000A(f) and regulations issued under that section. As described in section 5000A(f), government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, and certain other health benefits coverage are minimum essential coverage.

(2) *Government-sponsored minimum essential coverage*—(i) *In general.* Except as provided in paragraph (c)(2)(ii) of this section, for purposes of section 36B, an individual is eligible for government-sponsored minimum essential coverage if the individual meets the criteria for coverage under a government-sponsored program described in section 5000A(f)(1)(A). The Commissioner may define eligibility for specific government-sponsored programs further in published guidance of general applicability, see § 601.601(d)(2) of this chapter.

(ii) *Special rule for coverage under the veteran's health care program under chapter 17 or 18 of Title 38, U.S.C.* An individual is eligible for minimum

essential coverage under the veteran's health care program authorized under chapter 17 or 18 of Title 38, U.S.C., only if the individual is enrolled in a veteran's health care program identified as minimum essential coverage in regulations issued under section 5000A.

(iii) *Time of eligibility*—(A) *In general*. An individual generally is treated as eligible for a government-sponsored program on the first day of the first full month in which the individual may receive benefits under the program. However, an individual who fails to complete the requirements necessary to receive benefits available under a government-sponsored program (other than a veteran's health care program) reasonably promptly is treated as eligible for government-sponsored minimum essential coverage as of the first day of the second calendar month following the event that establishes eligibility under paragraph (c)(2)(i) of this section.

(B) *Retroactive effect of eligibility determination*. If an individual receiving advance credit payments is determined to be eligible for government-sponsored minimum essential coverage that is effective retroactively (such as Medicaid), the individual is treated as eligible for minimum essential coverage under that program no earlier than the first day of the first calendar month beginning after the approval.

(iv) *Determination of Medicaid or Children's Health Insurance Program (CHIP) ineligibility*. 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 an Exchange determines that the individual is not eligible for the program when the individual enrolls in the qualified health plan.

(v) *Examples*. The following examples illustrate the provisions of this paragraph (c)(2).

Example 1. Delay in coverage effectiveness. On April 10, Taxpayer D applies for coverage under a government-sponsored health care program. D's application is approved on July 12 but her coverage is not effective until September 1. Under paragraph (c)(2)(iii)(A) of this section, D is eligible for government-sponsored minimum essential coverage on September 1.

Example 2. Time of eligibility. Taxpayer E turns 65 on June 3 and becomes eligible for Medicare. Under section 5000A(f)(1)(A), Medicare is minimum essential coverage. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare on June 11 and may receive benefits immediately. Under paragraph (c)(2)(iii)(A) of this section, E is eligible for government-sponsored minimum essential coverage on July 1, the first day of the first full month that E may receive benefits under the program.

Example 3. Time of eligibility, individual fails to complete necessary requirements. The facts are the same as in *Example 2*, except that E fails to enroll in the Medicare coverage. E is treated as eligible for government-sponsored minimum essential coverage under paragraph (c)(2)(iii)(A) of this section as of August 1, the first day of the second month following the event that establishes eligibility (E turning 65).

Example 4. Retroactive effect of eligibility. On April 10, 2015, Taxpayer G applies for coverage under the Medicaid program. G's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (c)(2)(iii)(B) of this section, G is eligible for government-sponsored minimum essential coverage on June 1, 2015, the first day of the first calendar month after approval.

Example 5. Determination of Medicaid ineligibility. In November 2014, Taxpayer H applies to the Exchange to enroll in a qualified health plan and for advance credit payments for 2015. The Exchange estimates that H's household income will be 140 percent of the federal poverty line for H's family size and determines that H is not eligible for Medicaid. The Exchange authorizes advance credit payments for H for 2015. H experiences a loss of household income in June 2015 but does not return to the Exchange in 2015 to apply for Medicaid benefits or report his change in income. H's household income for 2015 is 130 percent of the federal poverty line (within the Medicaid income threshold). Under paragraph (c)(2)(iv) of this section, H is treated as not eligible for Medicaid for 2015.

Example 6. Mid-year Medicaid eligibility redetermination. The facts are the same as in *Example 5*, except that H returns to the Exchange in July 2015 and the Exchange determines H is eligible for Medicaid. The Exchange discontinues H's advance credit payments effective August 1. Under paragraphs (c)(2)(iii)(B) and (c)(2)(iv) of this section, H is treated as not eligible for Medicaid for the coverage months when H is covered by a qualified health plan. H is eligible for government-sponsored minimum essential coverage for the coverage months after H is approved for Medicaid, August through December 2015.

(3) *Employer-sponsored minimum essential coverage*—(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 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. Government-sponsored programs described in section 5000A(f)(1)(A) are not eligible employer-sponsored plans.

(ii) *Plan year*. For purposes of this paragraph (c)(3), a plan year is 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).

(iii) *Eligibility for coverage months during a plan year*—(A) *In general*. An employee or related individual may be eligible for minimum essential coverage under an eligible employer-sponsored plan for a coverage 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.

(B) *Example*. The following example illustrates the provisions of this paragraph (c)(3)(iii).

Example. (i) Taxpayer B is an employee of Employer X. X offers its employees a health insurance plan that has a plan year (within the meaning of paragraph (c)(3)(ii) of this section) from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. B does not enroll in X's plan for the plan year October 1, 2014, to September 30, 2015. In November 2014 B enrolls in a qualified health plan through an Exchange for calendar year 2015.

(ii) B could have enrolled in X's plan during the August 1 to September 15 enrollment period. Therefore, unless X's plan is not affordable for B or does not provide minimum value, B is eligible for minimum essential coverage for the months that B is enrolled in the qualified health plan during X's plan year (January through September 2015).

(iv) *Special rule for continuation coverage*. An individual who may enroll in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for minimum essential coverage only if the individual enrolls in the coverage.

(v) *Affordable coverage*—(A) *In general*—(1) *Affordability*. Except as provided in paragraph (c)(3)(v)(A)(2) of this section, an eligible employer-sponsored plan is affordable for an employee or a related individual if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage for the taxable year does not exceed the required contribution percentage (as defined in paragraph (c)(3)(v)(B) of this section) of the applicable taxpayer's household income for the taxable year.

(2) *Employee safe harbor*. An employer-sponsored plan is treated as not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a qualified health plan for a period coinciding with the plan year (in whole or in part), an Exchange determines that the eligible

employer-sponsored plan is not affordable.

(B) *Required contribution percentage.* The required contribution percentage is 9.5 percent. The percentage may be adjusted in published guidance of general applicability, see § 601.601(d)(2) of this chapter, for taxable years beginning after December 31, 2014, to reflect rates of premium growth relative to growth in income and, for taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

(C) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3)(v). Unless stated otherwise, in each example the taxpayer is single and has no dependents, the employer's plan is an eligible employer-sponsored plan and provides minimum value, the employee is not eligible for other minimum essential coverage, and the taxpayer, related individual, and employer-sponsored plan have a calendar taxable year.

Example 1. Basic determination of affordability. In 2014 Taxpayer C has household income of \$47,000. C is an employee of Employer X, which offers its employees a health insurance plan that requires C to contribute \$3,450 for self-only coverage for 2014 (7.3 percent of C's household income). Because C's required contribution for self-only coverage does not exceed 9.5 percent of household income, under paragraph (c)(3)(v)(A)(1) of this section, X's plan is affordable for C, and C is eligible for minimum essential coverage for all months in 2014.

Example 2. Basic determination of affordability for a related individual. The facts are the same as in *Example 1*, except that C is married to J and X's plan requires C to contribute \$5,300 for coverage for C and J for 2014 (11.3 percent of C's household income). Because C's required contribution for self-only coverage (\$3,450) does not exceed 9.5 percent of household income, under paragraph (c)(3)(v)(A)(1) of this section, X's plan is affordable for C and J, and C and J are eligible for minimum essential coverage for all months in 2014.

Example 3. Determination of unaffordability at enrollment. (i) Taxpayer D is an employee of Employer X. In November 2013 the Exchange in D's rating area projects that D's 2014 household income will be \$37,000. It also verifies that D's required contribution for self-only coverage under X's health insurance plan will be \$3,700 (10 percent of household income). Consequently, the Exchange determines that X's plan is unaffordable. D enrolls in a qualified health plan and not in X's plan. In December 2014, X pays D a \$2,500 bonus. Thus, D's actual 2014 household income is \$39,500 and D's required contribution for coverage under X's plan is 9.4 percent of household income.

(ii) Based on D's actual 2014 household income, D's required contribution does not exceed 9.5 percent of household income and

X's health plan is affordable for D. However, when D enrolled in a qualified health plan for 2014, the Exchange determined that X's plan was not affordable for D for 2014. Consequently, under paragraph (c)(3)(v)(A)(2) of this section, X's plan is treated as not affordable for D and D is treated as not eligible for minimum essential coverage for 2014.

Example 4. Determination of unaffordability for plan year. The facts are the same as in *Example 3*, except that X's employee health insurance plan year is September 1 to August 31. The Exchange in D's rating area determines in August 2014 that X's plan is unaffordable for D based on D's projected household income for 2014. D enrolls in a qualified health plan as of September 1, 2014. Under paragraph (c)(3)(v)(A)(2) of this section, X's plan is treated as not affordable for D and D is treated as not eligible for minimum essential coverage under X's plan for the coverage months September to December 2014 and January through August 2015.

Example 5. Determination of unaffordability for part of plan year. (i) Taxpayer E is an employee of Employer X beginning in May 2015. X's employee health insurance plan year is September 1 to August 31. E's required contribution for self-only coverage for May through August is \$150 per month (\$1,800 for the full plan year). The Exchange in E's rating area determines E's household income for purposes of eligibility for advance credit payments as \$18,000. E's actual household income for the 2015 taxable year is \$20,000.

(ii) Whether coverage under X's plan is affordable for E is determined for the remainder of X's plan year (May through August). E's required contribution for a full plan year (\$1,800) exceeds 9.5 percent of E's household income ($1,800/18,000 = 10$ percent). Therefore, the Exchange determines that X's coverage is unaffordable for May through August. Although E's actual household income for 2015 is \$20,000 (and E's required contribution of \$1,800 does not exceed 9.5 percent of E's household income), under paragraph (c)(3)(v)(A)(2) of this section, X's plan is treated as unaffordable for E for the part of the plan year May through August 2015. Consequently, E is not eligible for minimum essential coverage under X's plan for the period May through August 2015.

Example 6. Affordability determined for part of a taxable year (part-year period). (i) Taxpayer F is an employee of Employer X. X's employee health insurance plan year is September 1 to August 31. F's required contribution for self-only coverage for the period September 2014 through August 2015 is \$150 per month or \$1,800 for the plan year. F does not ask the Exchange in his rating area to determine whether X's coverage is affordable for F. F does not enroll in X's plan during X's open season but enrolls in a qualified health plan for September through December 2014. F's household income in 2014 is \$18,000.

(ii) Because F is a calendar year taxpayer and Employer X's plan is not a calendar year plan, F must determine the affordability of X's coverage for the part-year period in 2014

(September–December). F determines the affordability of X's plan for the September through December 2014 period by comparing the annual premiums (\$1,800) to F's 2014 household income. F's required contribution of \$1,800 is 10 percent of F's 2014 household income. Because F's required contribution exceeds 9.5 percent of F's 2014 household income, X's plan is not affordable for F for the part-year period September through December 2014 and F is not eligible for minimum essential coverage under X's plan for that period.

(iii) F enrolls in Exchange coverage for 2015 and does not ask the Exchange to determine whether X's coverage is affordable. F's 2015 household income is \$20,000.

(iv) F must determine if X's plan is affordable for the part-year period January 2015 through August 2015. F's annual required contribution (\$1,800) is 9 percent of F's 2015 household income. Because F's required contribution does not exceed 9.5 percent of F's 2015 household income, X's plan is affordable for F for the part-year period January through August 2015 and F is eligible for minimum essential coverage for that period.

Example 7. Coverage unaffordable at year end. Taxpayer G is employed by Employer X. In November 2014 the Exchange in G's rating area determines that G is eligible for affordable employer-sponsored coverage for 2015. G nonetheless enrolls in a qualified health plan for 2015 but does not receive advance credit payments. G's 2015 household income is less than expected and G's required contribution for employer-sponsored coverage for 2015 exceeds 9.5 percent of G's actual 2015 household income. Under paragraph (c)(3)(v)(A)(1) of this section, G is not eligible for minimum essential coverage for 2015 and, if otherwise eligible, G may claim a premium tax credit.

(vi) *Minimum value.* An eligible employer-sponsored plan provides minimum value only if the plan's share of the total allowed costs of benefits provided under the plan (as determined under regulations issued by the Secretary of Health and Human Services under section 1302(d)(2) of the Affordable Care Act (42 U.S.C. 18022(d)(2))) is at least 60 percent.

(vii) *Enrollment in eligible employer-sponsored plan—(A) In general.* The requirements of affordability and minimum value do not apply if an individual enrolls in an eligible employer-sponsored plan.

(B) *Example.* The following example illustrates the provisions of this paragraph (c)(3)(vii).

Example. Taxpayer H is employed by Employer X in 2014. H's required contribution for employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's plan for 2014. Under paragraph (c)(3)(vii) of this section, H is eligible for minimum essential coverage for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.

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

(a) *In general.* A taxpayer's premium assistance credit amount for a taxable year is the sum of the premium assistance amounts determined under paragraph (d) of this section for all coverage months for individuals in the taxpayer's family.

(b) *Definitions.* For purposes of this section—

(1) The cost of a qualified health plan is the premium the plan charges; and

(2) The term *coverage family* refers to members of the taxpayer's family who are not eligible for minimum essential coverage (other than coverage in the individual market), are lawfully present in the United States, and are not incarcerated (except pending disposition of charges).

(c) *Coverage month*—(1) *In general.* A month is a coverage month for an individual if, as of the first day of the month—

(i) The individual is covered by a qualified health plan enrolled in through an Exchange;

(ii) The individual's premiums for coverage under the plan are paid by the taxpayer or by an advance credit payment; and

(iii) The individual is not eligible for minimum essential coverage (within the meaning of § 1.36B-2(c)) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(2) *Premiums paid for the taxpayer.* Premiums another person pays for coverage of the taxpayer, taxpayer's spouse, or dependent are treated as paid by the taxpayer.

(3) *Examples.* The following examples illustrate the provisions of this paragraph (c). In each example, unless stated otherwise, the individuals are not eligible for minimum essential coverage other than coverage in the individual market and the taxpayer is an applicable taxpayer.

Example 1. (i) Taxpayer M is single with no dependents. In December 2013 M enrolls in a qualified health plan for 2014 and the Exchange approves advance credit payments. On May 15, 2014, M enlists in the U.S. Army and is eligible immediately for government-sponsored minimum essential coverage.

(ii) Under paragraph (c)(1) of this section, January through May 2014 are coverage months for M. June through December 2014 are not coverage months because M is eligible for minimum essential coverage for those months. Thus, under paragraph (a) of this section, M's premium assistance credit amount for 2014 is the sum of the premium assistance amounts for the months January through May.

Example 2. (i) Taxpayer N has one dependent, S. S is eligible for government-

sponsored minimum essential coverage. N is not eligible for minimum essential coverage. N enrolls in a qualified health plan for 2014 and the Exchange approves advance credit payments. On August 1, 2014, S loses eligibility for minimum essential coverage. N cancels the qualified health plan that covers only N and enrolls in a qualified health plan that covers N and S for August through December 2014.

(ii) Under paragraph (c)(1) of this section, January through December of 2014 are coverage months for N and August through December are coverage months for N and S. N's premium assistance credit amount for 2014 is the sum of the premium assistance amounts for these coverage months.

Example 3. (i) O and P are the divorced parents of T. Under the divorce agreement between O and P, T resides with P and P claims T as a dependent. However, O must pay premiums for health insurance for T. P enrolls T in a qualified health plan for 2014. O pays the premiums to the insurance company.

(ii) Because P claims T as a dependent, P (and not O) may claim a premium tax credit for coverage for T. See § 1.36B-2(a). Under paragraph (c)(2) of this section, the premiums that O pays for coverage for T are treated as paid by P. Thus, the months when T is covered by a qualified health plan are coverage months under paragraph (c)(1) of this section in computing P's premium tax credit under paragraph (a) of this section.

(d) *Premium assistance amount.* 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 in which a taxpayer or a member of the taxpayer's family enrolls; or

(2) The excess of the adjusted monthly premium for the applicable benchmark plan over $\frac{1}{12}$ of the product of a taxpayer's household income and the applicable percentage for the taxable year.

(e) *Adjusted monthly premium.* The adjusted monthly premium is the premium an insurer would charge for the applicable benchmark plan to cover all members of the taxpayer's coverage family, adjusted only for the age of each member of the coverage family as allowed under section 2701 of the Public Health Service Act (42 U.S.C. 300gg).

(f) *Applicable benchmark plan*—(1) *In general.* Except as otherwise provided in this paragraph (f), the applicable benchmark plan for a 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 at the time a taxpayer or family member enrolls in a qualified health plan through the Exchange in 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.* If an Exchange offers categories of family coverage (for example, two adults, one adult with children, two or more adults with children, or children only), the applicable benchmark plan for family coverage is the coverage category that applies to the members of the taxpayer's coverage family who enroll in a qualified health plan (such as a plan covering two adults if the members of taxpayer's coverage family are two adults).

(3) *Second lowest cost silver plan not covering the taxpayer's family.* If the applicable benchmark plan determined under paragraphs (f)(1) and (f)(2) of this section does not cover all members of a taxpayer's coverage family (for example, because family members reside in different rating areas), the premium for the applicable benchmark plan is the sum of the premiums for the applicable benchmark plans determined under paragraphs (f)(1) and (f)(2) of this section that cover the components of the taxpayer's coverage family.

(4) *Benchmark plan terminates or closes to enrollment.* A qualified health plan that is the applicable benchmark plan under this paragraph (f) 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.

(5) *Examples.* The following examples illustrate the rules of this paragraph (f). In each example, unless otherwise stated, the taxpayer is eligible to receive a premium tax credit.

Example 1. Single taxpayer with no dependents. Taxpayer V is single and resides with his 24-year-old daughter but may not claim her as a dependent. Taxpayer V purchases family coverage for himself and his daughter. The exchange in V's rating area offers only self-only and family coverage categories. Under paragraph (f)(1)(i)(A) of this section, V's applicable benchmark plan is the second lowest cost silver self-only plan. But see paragraph (h) of this section for computing the credit when multiple taxpayers are covered by one qualified health plan.

Example 2. Single taxpayer with one dependent, two coverage categories. The facts are the same as in *Example 1*, except that V

also resides with his teenage son and claims him as a dependent. V purchases family coverage for himself, his son, and his daughter. Under paragraph (f)(1)(ii) of this section, V's applicable benchmark plan is the second lowest cost silver family plan.

Example 3. Single taxpayer with one dependent, multiple coverage categories. The facts are the same as in *Example 2*, except that the Exchange where V resides offers a category of coverage for one adult and children. Under paragraphs (f)(1)(ii) and (f)(2) of this section, V's applicable benchmark plan is the second lowest cost silver plan for one adult plus children.

Example 4. Single taxpayer with one dependent, multiple coverage categories. The facts are the same as in *Example 2*, except that the Exchange where V resides offers a category of coverage for one adult and one child in addition to coverage for one adult and children. Under paragraphs (f)(1)(ii) and (f)(2) of this section, V's applicable benchmark plan is the second lowest cost silver plan for one adult and one child.

Example 5. Applicable benchmark plan unrelated to coverage purchased. Taxpayers W and X, who are married, reside with X's two teenage daughters, whom they claim as dependents. The Exchange where W and X reside offers a category of coverage for one adult plus children. W and X purchase self-only coverage for W and one adult plus children coverage for X and X's daughters. Under paragraph (f)(1)(ii) of this section, W's and X's applicable benchmark plan is the second lowest cost silver family plan.

Example 6. Minimum essential coverage for some coverage months. Taxpayer Y claims his daughter as a dependent. Y and his daughter enroll in a qualified health plan for 2014. The exchange in Y's rating area offers only self-only and family coverage categories. Y, but not his daughter, is eligible for government-sponsored minimum essential coverage for September to December 2014. Thus, under paragraph (c)(1)(iii) of this section, January through December are coverage months for Y's daughter and January through August are coverage months for Y. 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, Y's applicable benchmark plan for January through August

is the second lowest cost silver family plan under paragraph (f)(1)(ii) of this section. Under paragraph (f)(1)(i)(C) of this section, Y's applicable benchmark plan for September through December is the second lowest cost silver self-only plan.

Example 7. Family member eligible for minimum essential coverage for the taxable year. The facts are the same as in *Example 6*, except that Y is not eligible for government-sponsored minimum essential coverage for any months and Y's daughter is eligible for government-sponsored minimum essential coverage for the entire year. Under paragraph (f)(1)(i)(C) of this section, Y's applicable benchmark plan is the second lowest cost silver self-only plan.

Example 8. Family required to buy multiple plans to obtain coverage. (i) Taxpayers X and Z are married and live in different Exchange rating areas. X and Z have one child, M, whom they claim as a dependent and who resides with X. X and M enroll in a qualified health plan covering one adult plus children through the Exchange in X's rating area, and Z enrolls in a qualified health plan providing self-only coverage through the Exchange in Z's rating area.

(ii) Under paragraph (f)(3) of this section, the premium for the applicable benchmark plan for computing X's and Z's premium assistance credit amount is the sum of the premium for the second lowest cost silver one adult plus children plan offered through the Exchange in X's rating area and the premium for the second lowest cost silver self-only plan offered through the Exchange in Z's rating area.

Example 9. Benchmark plan closes to new enrollees during the year. Taxpayers X, Y, and Z each have coverage families consisting of two adults. In the rating area where X, Y, and Z reside, Plan 2 is the second lowest cost silver plan and Plan 3 is the third lowest cost silver plan covering two adults offered through the Exchange. The X and Y families each enroll in a qualified health plan that is not the applicable benchmark plan in November during the regular 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 Z family enrolls in a qualified health plan in July. Under paragraphs (f)(1), (f)(2), and (f)(4) of this section, the applicable

benchmark plan is Plan 2 for X and Y for all coverage months during the year. The applicable benchmark plan for Z is Plan 3, because Plan 2 is not offered through the Exchange when the Z family enrolls.

Example 10. Benchmark plan terminates for all enrollees during the year. The facts are the same as in *Example 9*, except that Plan 2 terminates for all enrollees on June 30. Under paragraphs (f)(1), (f)(2), and (f)(4) of this section, Plan 2 is the applicable benchmark plan for X and Y for all coverage months during the year and Plan 3 is the applicable benchmark plan for Z.

(g) *Applicable percentage—(1) In general.* The applicable percentage multiplied by a taxpayer's household income determines the taxpayer's required share of premiums for the benchmark plan. This amount is subtracted from the adjusted monthly premium for the applicable benchmark plan when computing the premium assistance amount. The applicable percentage is computed by first determining the percentage that the taxpayer's household income bears to the federal poverty line for the taxpayer's family size. The resulting federal poverty line percentage is then compared to the income categories described in the table in paragraph (g)(2) of this section (or successor tables). An applicable percentage within an income category increases on a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. The applicable percentages in the table may be adjusted in published guidance of general applicability, see § 601.601(d)(2) of this chapter, for taxable years beginning after December 31, 2014, to reflect rates of premium growth relative to growth in income and, for taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

(2) *Applicable percentage table.*

Household income percentage of federal poverty line	Initial percentage	Final percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but less than 400%	9.5	9.5

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

Example 1. A's household income is 275 percent of the federal poverty line for A's family size for that taxable year. In the table in paragraph (g)(2) of this section, the initial percentage for a taxpayer with household income of 250 to 300 percent of the federal

poverty line is 8.05 and the final percentage is 9.5. A's federal poverty line percentage of 275 percent is halfway between 250 percent and 300 percent. Thus, rounded to the nearest one-hundredth of one percent, A's applicable percentage is 8.78, which is halfway between the initial percentage of 8.05 and the final percentage of 9.5.

Example 2. (i) B's household income is 210 percent of the federal poverty line for B's family size. In the table in paragraph (g)(2) of this section, the initial percentage for a taxpayer with household income of 200 to 250 percent of the federal poverty line is 6.3 and the final percentage is 8.05. B's applicable percentage is 6.65, computed as follows:

(ii) Determine the excess of B's FPL percentage (210) over the initial household income percentage in B's range (200), which is 10. Determine the difference between the initial household income percentage in the taxpayer's range (200) and the ending household income percentage in the taxpayer's range (250), which is 50. Divide the first amount by the second amount:

$$210 - 200 = 10$$

$$250 - 200 = 50$$

$$10/50 = .20.$$

(iii) Compute the difference between the initial premium percentage (6.3) and the second premium percentage (8.05) in the taxpayer's range; $8.05 - 6.3 = 1.75$.

(iv) Multiply the amount in the first calculation (.20) by the amount in the second calculation (1.75) and add the product (.35) to the initial premium percentage in B's range (6.3), resulting in B's applicable percentage of 6.65:

$$.20 \times 1.75 = .35$$

$$6.3 + .35 = 6.65.$$

(h) *Plan covering more than one family*—(1) *In general.* If a single qualified health plan covers more than one family, each applicable taxpayer covered by the plan may claim a premium tax credit, if otherwise allowable. Each taxpayer computes the credit using that taxpayer's applicable percentage, household income, and the benchmark plan that applies to the taxpayer under paragraph (f) of this section. In determining whether the amount computed under paragraph (d)(1) of this section (the premiums for the qualified health plan in which the taxpayer enrolls) is less than the amount computed under paragraph (d)(2) of this section (the benchmark plan premium minus the product of household income and the applicable percentage), the premiums paid are allocated to each taxpayer in proportion to the premiums for each taxpayer's benchmark plan.

(2) *Example.* The following example illustrates the rules of this paragraph (h).

Example. (i) Taxpayers A and B enroll in a single qualified health plan. B is A's 25-year-old child who is not A's dependent. B has no dependents. The plan covers A, B, and A's two children who are A's dependents. The premium for the plan in which A and B enroll is \$15,000. The premium for the second lowest cost silver family plan is \$12,000 and the premium for the second lowest cost silver self-only plan is \$6,000. A and B are applicable taxpayers and otherwise eligible to claim the premium tax credit.

(ii) Under paragraph (h)(1) of this section, both A and B may claim premium tax credits. A computes her credit using her household income, a family size of three, and a

benchmark plan premium of \$12,000. B computes his credit using his household income, a family size of one, and a benchmark plan premium of \$6,000.

(iii) In determining whether the amount in paragraph (d)(1) of this section (the premiums for the qualified health plan A and B purchase) is less than the amount in paragraph (d)(2) of this section (the benchmark plan premium minus the product of household income and the applicable percentage), the \$15,000 premiums paid are allocated to A and B in proportion to the premiums for their applicable benchmark plans. Thus, the portion of the premium allocated to A is \$10,000 ($\$15,000 \times \$12,000 / \$18,000$) and the portion allocated to B is \$5,000 ($\$15,000 \times \$6,000 / \$18,000$).

(i) [Reserved]

(j) *Additional benefits*—(1) *In general.* If a qualified health plan offers benefits in addition to the essential health benefits a qualified health plan must provide under section 1302 of the Affordable Care Act (42 U.S.C. 18022), or a State requires a qualified health plan to cover benefits in addition to these essential health benefits, the portion of the premium for the plan properly allocable to the additional benefits is excluded from the monthly premiums under paragraph (d)(1) or (d)(2) of this section.

(2) *Method of allocation.* The portion of the premium properly allocable to additional benefits is determined under regulations issued by the Secretary of Health and Human Services. See section 36B(b)(3)(D).

(k) *Pediatric dental coverage*—(1) *In general.* For purposes of determining the amount of the monthly premium a taxpayer pays for coverage under paragraph (d)(1) of this section, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)) (Affordable Care Act dental plan), the portion of the premium for the Affordable Care Act dental plan that is properly allocable to pediatric dental benefits that are essential benefits required to be provided by a qualified health plan is treated as a premium payable for the individual's qualified health plan.

(2) *Method of allocation.* [Reserved]

(l) *Families including individuals not lawfully present*—(1) *In general.* If one or more individuals for whom a taxpayer is allowed a deduction under section 151 are not lawfully present (within the meaning of § 1.36B-1(g)), the percentage a taxpayer's household income bears to the federal poverty line for the taxpayer's family size for purposes of determining the applicable percentage under paragraph (g) of this section is determined by excluding

individuals who are not lawfully present from family size and by determining household income in accordance with paragraph (l)(2) of this section.

(2) *Revised household income computation*—(i) *Statutory method.* For purposes of paragraph (l)(1) of this section, household income is equal to the product of the taxpayer's household income (determined without regard to this paragraph (l)(2)) and a fraction—

(A) The numerator of which is the federal poverty line for the taxpayer's family size determined by excluding individuals who are not lawfully present; and

(B) The denominator of which is the federal poverty line for the taxpayer's family size determined by including individuals who are not lawfully present.

(ii) *Comparable method.* [Reserved]

§ 1.36B-4 Reconciling the premium tax credit with advance credit payments.

(a) *Reconciliation*—(1) *In general.* The amount of credit allowed under section 36B and this section is reconciled with advance credit payments on a taxpayer's income tax return for a taxable year. A taxpayer whose premium tax credit for the taxable year exceeds the taxpayer's advance credit payments may receive the excess as an income tax refund. A taxpayer whose advance credit payments for the taxable year exceed the taxpayer's premium tax credit owes the excess as an additional income tax liability.

(2) *Credit computation.* The premium assistance credit amount is computed on the taxpayer's return using the taxpayer's household income and family size for the taxable year. Thus, the taxpayer's contribution amount (household income for the taxable year times the applicable percentage) is determined using the taxpayer's household income and family size at the end of the taxable year. If the applicable benchmark plan changes during the taxable year, the taxpayer may be required to use a different applicable benchmark plan to determine the premium assistance amounts for the coverage months.

(3) *Limitation on additional tax*—(i) *In general.* The additional tax imposed under paragraph (a)(1) of this section on a taxpayer whose household income is less than 400 percent of the federal poverty line is limited to the amounts provided in the table in paragraph (a)(3)(ii) of this section (or successor tables). For taxable years beginning after December 31, 2014, the limitation amounts may be adjusted in published guidance of general applicability, see

§ 601.601(d)(2) of this chapter, to reflect changes in the consumer price index.

(ii) *Additional tax limitation table.*

Household income percentage of federal poverty line	Limitation amount for taxpayers whose tax is determined under section 1(c)	Limitation amount for all other taxpayers
Less than 200%	\$300	\$600
At least 200% but less than 300%	750	1,500
At least 300% but less than 400%	1,250	2,500

(4) *Examples.* The rules of this paragraph (a) are illustrated by the following examples. Unless otherwise stated, in each example the taxpayer is allowed a premium tax credit, has a calendar taxable year, and files an income tax return for the taxable year.

Example 1. Household income increases.

(i) Taxpayer A is single and has no dependents. The Exchange in A's rating area projects A's 2014 household income to be \$27,225 (250 percent of the federal poverty line for a family of one, applicable percentage 8.05). A enrolls in a qualified health plan. The annual premium for the applicable benchmark plan is \$5,200. A's advance credit payments are \$3,008 (benchmark plan premium of \$5,200 less contribution amount of \$2,192 (projected household income of \$27,225 × .0805) = \$3,008).

(ii) A's household income for 2014 is \$32,800, which is 301 percent of the federal poverty line for a family of one (applicable percentage 9.5). Consequently, A's premium tax credit for 2014 is \$2,084 (benchmark plan premium of \$5,200 less contribution amount of \$3,116 (household income of \$32,800 × .095)). Because A's advance credit payments for 2014 are \$3,008 and A's 2014 credit is \$2,084, A has excess advance payments of \$924. Under paragraph (a)(1) of this section, A's tax liability for 2014 is increased by \$924.

Example 2. Household income decreases.

The facts are the same as in *Example 1*, except that A's actual household income for 2014 is \$21,780 (200 percent of the federal poverty line for a family of one, applicable percentage 6.3). Consequently, A's premium tax credit for 2014 is \$3,828 (\$5,200 benchmark plan premium less contribution amount of \$1,372 (household income of \$21,780 × .063)). Because A's advance credit payments for 2014 are \$3,008, A is allowed an additional credit of \$820 (\$3,828 less \$3,008).

Example 3. Family size decreases.

(i) Taxpayers B and C are married and have two children (ages 17 and 20) whom they claim as their dependents in 2013. The Exchange in their rating area projects their 2014 household income to be \$61,460 (275 percent of the federal poverty line for a family of four, applicable percentage 8.78). B and C enroll in a qualified health plan for 2014 that covers the four family members. The annual premium for the applicable benchmark plan is \$14,100. B and C's advance credit payments for 2014 are \$8,704 (benchmark plan premium of \$14,100 less contribution amount of \$5,396 (projected household income of \$61,460 × .0878)).

(ii) In 2014 B and C do not claim their 20-year old child as their dependent. Consequently, B and C's family size for 2014 is three and their household income is 332 percent of the federal poverty line for a family of three (applicable percentage 9.5). Their premium tax credit for 2014 is \$8,261 (\$14,100 benchmark plan premium less \$5,839 contribution amount (household income of \$61,460 × .095)). Because B and C's advance credit payments for 2014 are \$8,704 and their 2014 credit is \$8,261, B and C have excess advance payments of \$443. Under paragraph (a)(1) of this section, B and C's tax liability for 2014 is increased by \$443. Because B and C's household income is below 400 percent of the federal poverty line, if B and C's excess advance payments exceeded \$2,500, under the limitation of paragraph (a)(3) of this section, B and C's additional tax liability would be limited to that amount.

Example 4. Repayment limitation does not apply. (i) Taxpayer D is single and has no dependents. The Exchange in D's rating area approves advance credit payments for D based on 2014 household income of \$38,115 (350 percent of the federal poverty line for a family of one, applicable percentage 9.5). D enrolls in a qualified health plan. The annual premium for the applicable benchmark plan is \$5,200. D's advance credit payments are \$1,579 (benchmark plan premium of \$5,200 less contribution amount of \$3,621 (projected household income of \$38,115 × .095) = \$3,621).

(ii) D's actual household income for 2014 is \$43,778, which is 402 percent of the federal poverty line for a family of one. D is not an applicable taxpayer and may not claim a premium tax credit. Additionally, the repayment limitation of paragraph (a)(3) of this section does not apply. Consequently, D has excess advance payments of \$1,579 (the total amount of the advance credit payments in 2014). Under paragraph (a)(1) of this section, D's tax liability for 2014 is increased by \$1,579.

Example 5. Coverage for less than a full taxable year. (i) Taxpayer F is single and has no dependents. In November 2013 the Exchange in F's rating area projects F's 2014 household income to be \$27,225 (250 percent of the federal poverty line for a family of one, applicable percentage 8.05). F enrolls in a qualified health plan. The annual premium for the applicable benchmark plan is \$5,200. F's monthly advance credit payment is \$251 (benchmark plan premium of \$5,200 less contribution amount of \$2,192 (projected household income of \$27,225 × .0805) = \$3,008; \$3,008/12 = \$251).

(ii) F begins a new job in August 2014 and is eligible for employer-sponsored minimum essential coverage for the period September through December 2014. F discontinues her Exchange coverage effective November 1, 2014. F's household income for 2014 is \$28,000 (257 percent of the federal poverty line for a family size of one, applicable percentage 8.25).

(iii) Under § 1.36B-3(a), F's premium assistance credit amount is the sum of the premium assistance amounts for the coverage months. Under § 1.36B-3(c)(1)(iii), a month in which an individual is eligible for minimum essential coverage other than coverage in the individual market is not a coverage month. Because F is eligible for employer-sponsored minimum essential coverage as of September 1, only the months January through August of 2014 are coverage months.

(iv) If F had 12 coverage months in 2014, F's premium tax credit would be \$2,890 (benchmark plan premium of \$5,200 less contribution amount of \$2,310 (household income of \$28,000 × .0825)). Because F has only eight coverage months in 2014, F's credit is \$1,927 (\$2,890/12 × 8). Because F does not discontinue her Exchange coverage until November 1, 2014, F's advance credit payments for 2014 are \$2,510 (\$251 × 10). Consequently, F has excess advance payments of \$583 (\$2,510 less \$1,927) and F's tax liability for 2014 is increased by \$583 under paragraph (a)(1) of this section.

Example 6. Changes in coverage months and applicable benchmark plan. (i) Taxpayer E claims one dependent, F. E is eligible for government-sponsored minimum essential coverage. E enrolls F in a qualified health plan for 2014. The Exchange in E's rating area projects E's 2014 household income to be \$29,420 (200 percent of the federal poverty line for a family of two, applicable percentage 6.3). The annual premium for E's applicable benchmark plan is \$5,200. E's monthly advance credit payment is \$279 (benchmark plan premium of \$5,200 less contribution amount of \$1,853 (projected household income of \$29,420 × .063) = \$3,347; \$3,347/12 = \$279).

(ii) On August 1, 2014, E loses her eligibility for government-sponsored minimum essential coverage. E cancels the qualified health plan that covers F and enrolls in a qualified health plan that covers E and F for August through December 2014. The annual premium for the applicable benchmark plan is \$10,000. The Exchange computes E's monthly advance credit payments for the period September through December as \$679 (benchmark plan premium

of \$10,000 less contribution amount of \$1,853 (projected household income of \$29,420 × .063) = \$8,147; \$8,147/12 = \$679). E's household income for 2014 is \$28,000 (190 percent of the federal poverty line, applicable percentage 5.84).

(iii) Under § 1.36B-3(c)(1), January through July of 2014 are coverage months for F and August through December are coverage months for E and F. Under paragraph (a)(2) of this section, E must compute her premium tax credit using the premium for the applicable benchmark plan for each coverage month. E's premium assistance credit amount for 2014 is the sum of the premium assistance amounts for all coverage months. E reconciles her premium tax credit with advance credit payments as follows:

Advance credit payments (Jan. to July)	\$1,953
Advance credit payments (Aug. to Dec.)	3,395
Total advance credit payments	5,348
Benchmark plan premium (Jan. to July)	3,033
Benchmark plan premium (Aug. to Dec.)	4,167
Total benchmark plan premium	7,200
Contribution amount (taxable year household income × applicable percentage)	1,635
Credit (total benchmark plan premium less required contribution, assuming not more than premium paid)	5,565

(iv) E's advance credit payments for 2014 are \$5,348. E's premium tax credit is \$5,565. Thus, E is allowed an additional credit of \$217.

Example 7. Part-year coverage and changes in coverage months and applicable benchmark plan. (i) The facts are the same as in *Example 7*, except that both E and F are eligible for government-sponsored minimum essential coverage for January and February 2014, and E enrolls F in a qualified health plan beginning in March 2014.

(ii) E reconciles her premium tax credit with advance credit payments as follows:

Advance credit payments (March to July)	\$1,395
Advance credit payments (Aug. to Dec.)	3,395
Total advance credit payments	4,790
Benchmark plan premium (March to July)	2,167
Benchmark plan premium (Aug. to Dec.)	4,166
Total benchmark plan premium	6,333
Contribution amount for 10 coverage months (taxable year household income × applicable percentage × 10/12)	1,363

Credit (total benchmark plan premium less required contribution, assuming not more than premium paid)

4,970

(iii) E's advance credit payments for 2014 are \$4,790. E's premium tax credit is \$4,970. Thus, E is allowed an additional credit of \$180.

(b) *Changes in filing status*—(1) *In general.* A taxpayer whose marital status changes during the taxable year computes the premium tax credit by using the applicable benchmark plan or plans for the taxpayer's marital status as of the first day of each coverage month. The taxpayer's contribution amount (household income for the taxable year times the applicable percentage) is determined using the taxpayer's household income and family size at the end of the taxable year.

(2) *Taxpayers not married to each other at the end of the taxable year.* Taxpayers who are married (within the meaning of section 7703) to each other during a taxable year but are not married to each other on the last day of the taxable year, and who are enrolled in the same qualified health plan at any time during the taxable year, must allocate the premium for the applicable benchmark plan, the premium for the plan in which the taxpayers enroll, and the advance credit payments for the period the taxpayers are married during the taxable year. The taxpayers may allocate these items to each former spouse in any proportion but must allocate all items in the same proportion. If the taxpayers cannot agree on an allocation, 50 percent of the premium for the applicable benchmark plan, the premiums for the plan in which the taxpayers enroll, and the advance credit payments for the period are allocated to each taxpayer. If a plan covers only one of these taxpayers for any period during a taxable year, the amounts for that period are allocated entirely to that taxpayer.

(3) *Married taxpayers filing separate tax returns.* The premium tax credit is allowed to married taxpayers only if they file joint returns. See § 1.36B-2(b)(2). Married taxpayers who receive advance credit payments and file their income tax returns as married filing separately have received excess advance payments. The taxpayers must allocate the advance credit payments to each taxpayer equally for purposes of determining their excess advance payment amounts under paragraph (a)(1) of this section. The repayment limitation described in paragraph (a)(3) of this section applies to each taxpayer based on the household income and family size reported on that taxpayer's return.

(4) *Examples.* The following examples illustrate the provisions of this paragraph (b). In each example, unless otherwise indicated, each taxpayer uses a calendar taxable year and no individuals are eligible for minimum essential coverage other than coverage in the individual market.

Example 1. Taxpayers marry during the taxable year. (i) P is a single taxpayer with no dependents. In 2013 the Exchange in the rating area where P resides determines that P's 2014 household income will be \$40,000 (367 percent of the federal poverty line, applicable percentage 9.5). P enrolls in a qualified health plan. The premium for the applicable benchmark plan is \$5,200. The Exchange approves advance credit payments of \$117 per month, computed as follows: \$5,200 benchmark plan premium minus contribution amount of \$3,800 ($\$40,000 \times .095$) equals \$1,400 (total advance credit); $\$1,400/12 = \117 .

(ii) Q is a single taxpayer with two dependents. In 2013 the Exchange in the rating area where Q resides determines that Q's 2014 household income will be \$35,000 (189 percent of the federal poverty line, applicable percentage 5.79). Q enrolls in a qualified health plan. The premium for the applicable benchmark plan is \$14,100. The Exchange approves advance credit payments of \$1,006 per month, computed as follows: \$14,100 benchmark plan premium minus contribution amount of \$2,027 ($\$35,000 \times .0579$) equals \$12,073 (total advance credit); $\$12,073/12 = \$1,006$.

(iii) P and Q marry on June 17, 2014, and enroll in one qualified health plan covering four family members, beginning July 1, 2014. The premium for the applicable benchmark plan is \$14,100. Based on household income of \$75,000 and a family size of four (336 percent of the federal poverty line, applicable percentage 9.5), the Exchange approves advance credit payments of \$581 per month, computed as follows: \$14,100 benchmark plan premium minus contribution amount of \$7,125 ($\$75,000 \times .095$) equals \$6,975 (total advance credit); $\$6,975/12 = \581 .

(iv) P and Q file a joint return for 2014 and report \$75,000 in household income and a family size of four. Under paragraph (b)(1) of this section, P and Q compute their credit at reconciliation using the premiums for the applicable benchmark plans that apply for the months married and the months not married, and their contribution amount based on their federal poverty line percentage at the end of the taxable year. P and Q reconcile their premium tax credit with advance credit payments as follows:

Advance payments for P (Jan. to June)	\$700
Advance payments for Q (Jan. to June)	6,036
Advance payments for P and Q (July to Dec.)	3,486
Total advance payments	10,222
Benchmark plan premium for P (Jan. to June)	2,600
Benchmark plan premium for Q (Jan. to June)	7,050

Benchmark plan premium for P and Q (July to Dec.)	7,050
Total benchmark plan premium	16,700
Contribution amount (taxable year household income × applicable percentage)	7,125
Credit (total benchmark plan premium less required contribution, assuming not more than premium paid)	9,575
Additional tax	647

(v) P's and Q's tax liability for 2014 is increased by \$647 under paragraph (a)(1) of this section.

Example 2. Taxpayers divorce during the taxable year, 50 percent allocation. (i) Taxpayers R and S are married and have two dependents. In 2013 the Exchange in the rating area where the family resides determines that their 2014 household income will be \$76,000 (340 percent of the federal poverty line for a family of 4, applicable percentage 9.5). R and S enroll in a qualified health plan for 2014. The premium for the applicable benchmark plan is \$14,100. The Exchange approves advance credit payments of \$573 per month, computed as follows:

	R	S
Allocated advance payments (Jan. to June)	\$1,720	\$1,720
Actual advance payments (July to Dec.)	4,200	2,292
Total advance payments	5,920	4,012
Allocated benchmark plan premium (Jan. to June)	3,525	3,525
Actual benchmark plan premium (July to Dec.)	7,050	2,600
Total benchmark plan premium	10,575	6,125
Contribution amount (taxable year household income × applicable percentage)	5,700	611
Credit (total benchmark plan premium less required contribution, assuming not more than premium paid)	4,875	5,514
Additional credit		1,502
Additional tax	1,045	

(vi) Under paragraph (a)(1) of this section, on their tax returns R's tax liability is increased by \$1,045 and S is allowed \$1,502 as additional credit.

Example 3. Taxpayers divorce during the taxable year, allocation in proportion to household income. (i) The facts are the same

\$14,100 benchmark plan premium minus R and S's contribution amount of \$7,220 (\$76,000 × .095) equals \$6,880 (total advance credit); \$6,880/12 = \$573.

(ii) R and S divorce on June 17, 2014, and obtain separate qualified health plans beginning July 1, 2014. R enrolls based on household income of \$60,000 and a family size of three (324 percent of the federal poverty line, applicable percentage 9.5). The premium for the applicable benchmark plan is \$14,100. The Exchange approves advance credit payments of \$700 per month, computed as follows: \$14,100 benchmark plan premium minus R's contribution amount of \$5,700 (\$60,000 × .095) equals \$8,400 (total advance credit); \$8,400/12 = \$700.

(iii) S enrolls based on household income of \$16,000 and a family size of one (147 percent of the federal poverty line, applicable percentage 3.82). The premium for the applicable benchmark plan is \$5,200. The Exchange approves advance credit payments of \$382 per month, computed as follows: \$5,200 benchmark plan premium minus S's contribution amount of \$611 (\$16,000 × .0382) equals \$4,589 (total advance credit); \$4,589/12 = \$382. R and S do not agree on an allocation of the premium for the

applicable benchmark plan, the premiums for the plan in which they enroll, and the advance credit payments for the period they were married in the taxable year.

(iv) Under paragraph (b)(1) of this section, R and S each compute their credit at reconciliation using the premiums for the applicable benchmark plans that apply to them for the months married and the months not married, and contribution amount based on their federal poverty line percentages at the end of the taxable year. Under paragraph (b)(2) of this section, because R and S do not agree on an allocation, R and S must equally allocate the benchmark plan premium (\$7,050) and the advance credit payments (\$3,440) for the six-month period January through June 2014 when they are married and enrolled in the same qualified health plan. Thus, R and S each are allocated \$3,525 of the benchmark plan premium (\$7,050/2) and \$1,720 of the advance credit payments (\$3,440/2) for January through June.

(v) R reports on his 2014 tax return \$60,000 in household income and family size of three. S reports on her 2014 tax return \$16,000 in household income and family size of one. R and S reconcile their premium tax credit with advance credit payments as follows:

	R	S
Allocated advance payments (Jan. to June)	\$2,718	\$722
Actual advance payments (July to Dec.)	4,200	2,292
Total advance payments	6,918	3,014
Allocated benchmark plan premium (Jan. to June)	5,570	1,480
Actual benchmark plan premium (July to Dec.)	7,050	2,600
Total benchmark plan premium	12,620	4,080
Contribution amount (taxable year household income × applicable percentage)	5,700	611
Credit (total benchmark plan premium less required contribution, assuming not more than premium paid)	6,920	3,469
Additional credit	2	455

as in *Example 2*, except that R and S decide to allocate the benchmark plan premium (\$7,050) and the advance credit payments (\$3,440) for January through June 2014 in proportion to their household incomes (79 percent and 21 percent). Thus, R is allocated \$5,570 of the benchmark plan premiums

(\$7,050 × .79) and \$2,718 of the advance credit payments (\$3,440 × .79), and S is allocated \$1,480 of the benchmark plan premiums (\$7,050 × .21) and \$722 of the advance credit payments (\$3,440 × .21). R and S reconcile their premium tax credit with advance credit payments as follows:

(ii) Under paragraph (a)(1) of this section, on their tax returns R is allowed an additional credit of \$2 and S is allowed an additional credit of \$455.

Example 4. Married taxpayers filing separate tax returns. (i) Taxpayers T and U are married and have two dependents. In 2013, the Exchange in the rating area where the family resides determines that their 2014 household income will be \$76,000 (340 percent of the federal poverty line for a family of 4, applicable percentage 9.5). T and U enroll in a qualified health plan for 2014. The premium for the applicable benchmark plan is \$14,100. The Exchange approves advance credit payments of \$573 per month, computed as follows: \$14,100 benchmark plan premium minus T and U's contribution amount of \$7,220 ($\$76,000 \times .095$) equals \$6,880 (total advance credit); $\$6,880/12 = \573 .

(ii) T and U file income tax returns for 2014 using a married filing separately filing status. T reports household income of \$60,000 and a family size of three (324 percent of the federal poverty line). U reports household income of \$16,000 and a family size of one (147 percent of the federal poverty line).

(iii) Because T and U are married but do not file a joint return for 2014, T and U are not applicable taxpayers and are not allowed a premium tax credit for 2014. See § 1.36B-2(b)(2). Under paragraph (b)(3) of this section, half of the advance credit payments ($\$6,880/2 = \$3,440$) is allocated to T and half is allocated to U for purposes of determining their excess advance payments. The repayment limitation described in paragraph (a)(3) of this section applies to T and U based on the household income and family size reported on each return. Consequently, T's tax liability for 2014 is increased by \$2,500 and U's tax liability for 2014 is increased by \$600.

§ 1.36B-5 Information reporting by Exchanges.

(a) *Information required to be reported.* An Exchange must report to the IRS and a taxpayer the following information for a qualified health plan the taxpayer enrolls in through the Exchange—

(1) The premium and category of coverage (such as self-only) for the applicable benchmark plans used to compute advance credit payments and the period coverage was in effect;

(2) The total premium for the coverage without reduction for advance credit payments or cost sharing;

(3) The aggregate amounts of any advance credit payments or cost sharing reductions;

(4) The name, address and taxpayer identification number (TIN) of the primary insured and the name and TIN of each other individual covered under the policy;

(5) All information provided to the Exchange at enrollment or during the taxable year, including any change in

circumstances, necessary to determine eligibility for and the amount of the premium tax credit;

(6) All information necessary to determine whether a taxpayer has received excess advance payments; and

(7) Any other information required in published guidance of general applicability, see § 601.601(d)(2) of this chapter.

(b) *Time and manner of reporting.* The Commissioner may provide rules in published guidance of general applicability, see § 601.601(d)(2) of this chapter, for the time and manner of reporting under this section.

Par. 3. Section 1.6011-8 is added to read as follows:

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

(a) *Requirement of return.* A taxpayer who receives advance payments of the premium tax credit under section 36B must file an income tax return for that taxable year on or before the fifteenth day of the fourth month following the close of the taxable year.

(b) *Effective/applicability date.* This section applies for taxable years ending after December 31, 2013.

Par. 4. In § 1.6012-1, paragraph (a)(2)(viii) is added to read as follows:

§ 1.6012-1 Individuals required to make returns of income.

(a) * * *

(2) * * *

(viii) For rules relating to returns required of taxpayers who receive advance payments of the premium tax credit under section 36B, see § 1.6011-8(a).

* * * * *

Steven T. Miller,

Deputy Commissioner for Services and Enforcement.

[FR Doc. 2011-20728 Filed 8-12-11; 8:45 am]

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 31

[REG-151687-10]

RIN 1545-BJ98

Withholding on Payments by Government Entities to Persons Providing Property or Services; Hearing

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of public hearing on proposed rulemaking.

SUMMARY: This document provides notice of public hearing on proposed regulations relating to withholding by government entities on payments to persons providing property or services.

DATES: The public hearing is being held on Monday, September 12, 2011, at 10 a.m. The IRS must receive outlines of the topics to be discussed at the public hearing by Friday, September 2, 2011.

ADDRESSES: The public hearing is being held in the IRS Auditorium, Internal Revenue Service Building, 1111 Constitution Avenue, NW., Washington, DC 20224. Send Submissions to CC:PA:LPD:PR (REG-151687-10), Room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday to CC:PA:LPD:PR (REG-151687-10), Couriers Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC or sent electronically via the Federal eRulemaking Portal at <http://www.regulations.gov> (REG-151687-10).

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, A.G. Kelley, (202) 622-6040; concerning submissions of comments, the hearing and/or to be placed on the building access list to attend the hearing Funmi Taylor at (202) 622-7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION: The subject of the public hearing is the notice of proposed rulemaking (REG-151687-10), that was published in the **Federal Register** on Monday, May 9, 2011 (76 FR 26678).

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing that submitted written comments by August 8, 2011, must submit an outline of the topics to be addressed and the amount of time to be denoted to each topic (Signed original and eight copies).

A period of 10 minutes is allotted to each person for presenting oral comments. After the deadline for receiving outlines has passed, the IRS will prepare an agenda containing the schedule of speakers. Copies of the agenda will be made available, free of charge, at the hearing or in the Freedom of Information Reading Room (FOIA RR) (Room 1621) which is located at the 11th and Pennsylvania Avenue, NW., entrance, 1111 Constitution Avenue, NW., Washington, DC.

Because of access restrictions, the IRS will not admit visitors beyond the immediate entrance area more than 30