Internal Revenue
bulletin

Bulletin No. 2012-24
June 11, 2012

HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

INCOME TAX

Rev. Rul. 2012–14, page 1012.

Income from discharge of indebtedness. This ruling amplifies Revenue Ruling 92–53, 1992–2 C.B. 48, by describing how discharged partnership excess nonrecourse debt is taken into account in measuring the insolvency of the partners under section 108(d)(3) of the Code. The ruling provides that to the extent discharged excess nonrecourse debt generates cancellation of indebtedness (COD) income that is allocated under section 704(b) (and the regulations thereunder), each partner treats its portion of the discharged excess nonrecourse debt related to such COD income as a liability in measuring insolvency under section 108(d)(3). Rev. Rul. 92–53 amplified.

T.D. 9590, page 986.

Final regulations under section 36B of the Code relate to the premium tax credit, enacted by section 1401 of the Affordable Care Act.

Notice 2012–37, page 1014.

This notice extends interim guidance under section 833 of the Code provided in Notice 2010–79 and Notice 2011–51 on the modification of section 833 treatment of certain health organizations. Notice 2011–51 modified and superseded.

ADMINISTRATIVE

Notice 2012–38, page 1014.

This notice solicits public comments on what additional guidance may be needed after Rev. Rul. 2006–57, which provides guidance on the use of smartcards, debit or credit cards, or other electronic media to provide qualified transportation fringes under sections 132(a)(5) and (f) of the Code, became effective on January 1, 2012. In particular, the notice requests public comments on a number of issues surrounding an employer's provision of transit benefits in light of changes in technology in transit benefit administration.

Finding Lists begin on page ii.

Department of the Treasury
Internal Revenue Service

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly and may be obtained from the Superintendent of Documents on a subscription basis. Bulletin contents are compiled semiannually into Cumulative Bulletins, which are sold on a single-copy basis.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.
This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.
This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.
To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.
This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

Section 36B.—Refundable Credit for Coverage Under a Qualified Health Plan

26 CFR 1.36B–0: Table of contents.

T.D. 9590

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Parts 1 and 602

Health Insurance Premium Tax Credit

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final 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, the Department of Defense and Full-Year Continuing Appropriations Act, 2011, and the 3% Withholding Repeal and Job Creation Act. These final regulations provide guidance to individuals who enroll in qualified health plans through Affordable Insurance Exchanges (Exchanges) and claim the premium tax credit, and to Exchanges that make qualified health plans available to individuals and employers.

DATES: *Effective Date:* These regulations are effective on May 23, 2012.

Comment Date: Comments will be accepted until August 21, 2012.

Applicability Date: For date of applicability, see §1.36B–1(o).

ADDRESSES: Comments should be submitted to Internal Revenue Service, CC:PA:LPD:PR (REG–131491–10), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044, or electronically to *www.regulations.gov* (IRS REG–131491–10). Alternatively, comments may be hand delivered between the hours of 8:00 a.m. and 4:00 p.m. Monday to Friday to CC:PA:LPD:PR (REG–131491–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, D.C. All comments will be available for public inspection and copying.

FOR FURTHER INFORMATION CONTACT: Shareen S. Pflanz, (202) 622–4920, or Andrew S. Braden, (202) 622–4960 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these regulations has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507(d)) under control number 1545–2232.

The collection of information in these final regulations is in §1.36B–5. The information will help the IRS 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). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid control number assigned by the Office of Management and Budget.

The estimated total annual reporting burden is 250,000 hours. The estimated annual burden per respondent is 5,000 hours. The estimated number of respondents is 50.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be sent to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:M:S, Washington, DC 20224, and 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.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and return information are confidential, as required by 26 U.S.C. 6103.

Background

This document contains final regulations that amend the Income Tax Regulations (26 CFR part 1) under section 36B relating to the premium tax credit. Section 36B was enacted by the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act). On August 17, 2011, a notice of proposed rulemaking (REG–131491–10) was published in the **Federal Register** (76 FR 50931). Written comments responding to the notice of proposed rulemaking were received. The comments are available for public inspection at *www.regulations.gov* or on request. A public hearing was held on November 17, 2011. After consideration of all the comments, the proposed regulations are adopted as amended by this Treasury decision. The comments and revisions are discussed in the preamble.

Explanation of Provisions and Summary of Comments

1. *Premium Tax Credit Definitions*

a. *Family size*

The proposed regulations define a taxpayer's family as the individuals for whom a taxpayer claims a deduction for a personal exemption under section 151 for the taxable year, which may include the taxpayer, the taxpayer's spouse, and dependents. The proposed regulations also clarify that the family includes individuals who are not applicable individuals under section 5000A(d) and thus are not subject

to the penalty for failing to maintain minimum essential coverage.

Commentators recommended clarifying that the family also includes individuals who are exempt under section 5000A(e) from the requirement to maintain minimum essential coverage. Accordingly, the final regulations clarify that a family may include all individuals not subject to the section 5000A penalty.

Some commentators disagreed with the rule in the proposed regulations that a taxpayer's family includes a child only if the taxpayer is allowed a dependency exemption deduction for the child. Commentators suggested that taxpayers should be able to compute a premium tax credit based on premiums for a child for whom the person is not allowed a dependency exemption deduction. Section 36B(d)(1) defines the family as the individuals for whom the taxpayer is allowed a personal exemption deduction under section 151. Accordingly, the final regulations do not adopt these comments. We note however, that the non-dependent child may be able to claim a premium tax credit if otherwise eligible. See §1.36B–3(h).

b. *Requirement to file a return for purposes of household income*

Under section 36B, household income includes the modified adjusted gross income of a dependent who is required to file a return of tax imposed by section 1. The final regulations conform to this statutory language, thus clarifying that household income does not include the modified adjusted gross income of a family member who is required to file a tax return solely to report tax imposed under Code sections other than section 1 (for example, the early distribution penalty imposed under section 72(q) or self-employment tax under section 1401).

c. *Modified adjusted gross income*

Under the proposed regulations, modified adjusted gross income is adjusted gross income increased by amounts excluded from gross income under section 911 and tax-exempt interest a taxpayer receives or accrues during the taxable year. The 3% Withholding Repeal and Job Creation Act, Public Law 112–56 (125 Stat. 711 (2011)), which was enacted after the proposed regulations were published, amended the definition of modified adjusted gross income to include Social Security benefits (as defined in section 86(d)) not included in gross income under section 86. The final regulations reflect this amendment.

d. *Lawfully present*

Under section 36B(c)(1)(B) and the proposed regulations, a taxpayer who is an individual lawfully present in the United States may be treated as an applicable taxpayer if the taxpayer's household income is under 100 percent of the Federal poverty line (FPL) and the taxpayer is not eligible for Medicaid. Under section 1321(f)(3) of the Affordable Care Act, an individual who is not lawfully present in the United States may not enroll in a qualified health plan through an Exchange. The proposed regulations define *lawfully present* by referencing 45 CFR 152.2, which also is referenced in defining *lawfully present* in proposed regulations on Exchanges under 45 CFR 155.20 issued by the Department of Health and Human Services (HHS).

Commentators requested that the final regulations expand the definition of lawfully present to include the categories of immigrants described in the Children's Health Insurance Program Reauthorization Act. One commentator stated that the final regulations should allow States to use existing administrative mechanisms to determine eligibility if those mechanisms are not more restrictive than Federal law.

To maintain consistency with the HHS Exchange final regulations, the final regulations define *lawfully present* by referencing 45 CFR 155.20, the definition in the HHS Exchange final regulations.

e. *Federal poverty line*

The proposed regulations define *Federal poverty line* by reference to the Federal poverty guidelines published annually by HHS. The Federal poverty guidelines for Alaska and Hawaii differ from the guidelines for the 48 contiguous states and the District of Columbia. The final regulations clarify that, if married taxpayers reside in separate States with different Federal poverty guidelines, or if a taxpayer resides in States with different Federal poverty guidelines during the year, the Federal poverty line that applies for purposes of section 36B and the associated regulations is the higher Federal poverty line (resulting in a lower percentage of the Federal poverty line for the taxpayers' household income and family size).

f. *Federally-facilitated Exchange*

Under the proposed regulations, the term *Exchange* has the same meaning as in 45 CFR 155.20, which provides that the term *Exchange* refers to a State Exchange, regional Exchange, subsidiary Exchange, and Federally-facilitated Exchange.

Commentators disagreed on whether the language in section 36B(b)(2)(A) limits the availability of the premium tax credit only to taxpayers who enroll in qualified health plans on State Exchanges.

The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

g. *Rating area*

The proposed regulations define *rating area* as an Exchange service area, as described in 45 CFR 155.20. Commentators suggested that an Exchange service area is different than a rating area as that term is used in section 36B(b)(3) for determining the applicable benchmark plan. The final regulations reserve the definition of rating area.

2. *Eligibility for the Premium Tax Credit*

a. *Applicable taxpayer*

Under section 36B(c)(1) and the proposed regulations, in general a taxpayer is an applicable taxpayer for a taxable year only if the taxpayer's household income for the taxable year is at least 100 percent but not more than 400 percent of the FPL

for the taxpayer's family size. Commentators requested that the final regulations treat a taxpayer whose household income exceeds 400 percent of the FPL for the taxpayer's family size as an applicable taxpayer if, at enrollment, the Exchange estimates that the taxpayer's household income will be between 100 and 400 percent of the FPL for the taxpayer's family size and approves advance credit payments. Other commentators advocated allowing taxpayers with household income above 400 percent of the FPL for their family size to be treated as eligible for a premium tax credit for the months before a change in circumstances affecting household income occurs or for the months for which the taxpayer receives advance payments.

The final regulations do not adopt these comments because they are contrary to the language of section 36B limiting the premium tax credit to taxpayers with household income for the taxable year at or below 400 percent of the FPL for the taxpayer's family size.

Commentators requested that the final regulations clarify that a taxpayer who has household income between 100 percent and 133 percent of the FPL but is not eligible for Medicaid qualifies for the premium tax credit. Under section 36B(c)(1)(A) and the proposed regulations, an applicable taxpayer who may claim the premium tax credit is a taxpayer with household income between 100 and 400 percent of the FPL for the family size. Thus, it is clear that a taxpayer with household income between 100 percent and 133 percent of the FPL for the taxpayer's family size may be an applicable taxpayer.

Commentators requested that the final regulations allow an individual who may be claimed as a dependent by another taxpayer to qualify as an applicable taxpayer for a taxable year if, for the taxable year, another taxpayer does not claim the individual as a dependent. The final regulations do not adopt this comment because it is inconsistent with section 36B(c)(1)(D), which provides that a premium tax credit is not allowed to any individual for whom a deduction under section 151 is "allowable to another taxpayer" for the taxable year.

b. *Incarceration*

Under section 1312(f) of the Affordable Care Act, individuals who are incarcerated (other than pending disposition of charges) may not enroll in a qualified health plan through an Exchange. The proposed regulations provide, however, that an individual who is incarcerated may be allowed a premium tax credit if a family member is enrolled in a qualified health plan.

A commentator suggested that the rules relating to incarcerated individuals should apply to individuals incarcerated pending disposition of charges, as is the case under the Medicaid program. The comment addresses an issue beyond the scope of the premium tax credit regulations. Standards for enrollment in a qualified health plan fall under rules within the jurisdiction of HHS.

c. *Minimum essential coverage*

i. Government-Sponsored Coverage

A. Time of eligibility

The proposed regulations provide that 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. The proposed regulations further provide that 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 the coverage on the first day of the second calendar month following the event that establishes eligibility.

Commentators asked that the final regulations allow individuals a certain amount of time to complete the requirements (such as submitting an application) necessary to obtain government-sponsored minimum essential coverage. Some commentators suggested that the final regulations could provide this period by defining "reasonably promptly" as 90 days after the event that establishes eligibility. Commentators requested that the final regulations allow exemptions from the 90-day period, however, when additional delay in receiving benefits occurs despite the good faith efforts of the taxpayer, for example as a result of inaction of a government agency or official.

To provide greater clarity, the final regulations delete the language "reasonably promptly" and extend this time period. Under the final regulations, an individual who fails to complete the requirements necessary to receive benefits available under a government-sponsored program by the last day of the third full calendar month following the event that establishes eligibility is treated as eligible for the coverage on the first day of the fourth calendar month. Because an individual who timely completes the necessary requirements is treated as eligible for government-sponsored minimum essential coverage no earlier than the first month that the individual may receive benefits, this 3-month time period does not include the time needed for a government agency to process an application.

The proposed regulations request comments on whether rules should provide flexibility if operational challenges prevent timely transition from coverage under a qualified health plan to coverage under a government-sponsored program. Commentators stated that the final regulations should provide that an individual transitioning from a qualified health plan to coverage under a government-sponsored program should not be treated as eligible for government-sponsored minimum essential coverage until the individual is able to effectively terminate his or her qualified health plan coverage. They expressed concern that an individual may be unable to discontinue advance credit payments by the beginning of a month for which the individual is eligible for government-sponsored coverage and could be responsible for an excess advance payment for that month.

The concerns expressed in these comments are addressed in the HHS final regulations on Exchanges. Under 45 CFR 155.430, an Exchange must permit an enrollee to terminate coverage in a qualified health plan no later than 14 days after the enrollee requests termination. For an enrollee who is newly eligible for Medicaid or the Children's Health Insurance Program (CHIP), 45 CFR 155.430(d)(2)(iv) provides that qualified health plan coverage terminates on the last day before Medicaid or CHIP coverage begins. These termination

rules enable individuals transitioning to coverage under a government-sponsored program to effectively terminate qualified health plan coverage (and liability for advance credit payments) before they are eligible for government-sponsored minimum essential coverage.

B. Definition of "eligible"

The proposed regulations provide that an individual is eligible for government-sponsored minimum essential coverage when an individual meets the requirements for coverage under the program. For administrative convenience, however, because the standards for eligibility in veterans' programs do not allow Exchanges to identify everyone who may be eligible for veterans' coverage at the time he or she is seeking an eligibility determination for advance payments of the premium tax credit, the proposed regulations provide that 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.

The final regulations conform the rules to amendments to section 5000A that delete the word "veteran's" in describing health care programs under chapter 17 or 18 of Title 38. Thus, the special rule for veterans' coverage may apply to individuals who are not veterans but are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (VA) or the VA's spina bifida program.

Commentators requested that the final regulations define eligibility for government-sponsored programs as actual enrollment for individuals suffering from end stage renal disease who become eligible for Medicare as a result of their diagnosis. Other commentators requested this treatment for any individual suffering from an acute illness who becomes eligible for a government-sponsored program. The commentators asserted that these seriously-ill individuals should be able to choose to remain enrolled in a qualified health plan with the benefit of a premium tax credit to maintain continuity of medical care, which may be disrupted if the individual loses eligibility for the premium tax credit and is required to move to a government-sponsored program in which the individual's medical provider does not participate.

Section 36B(c)(2)(B) establishes a clear structure under which eligibility for government-sponsored minimum essential coverage in a given month precludes including an individual in a taxpayer's coverage family for purposes of computing the premium assistance amount for that month. In keeping with the statutory scheme, the final regulations do not adopt these comments. However, the IRS and the Treasury Department expect to publish additional guidance, see §601.601(d)(2), clarifying when or if an individual becomes "eligible for government-sponsored minimum essential coverage" when the eligibility for that coverage is a result of a particular illness or condition. For example, as the preamble to the proposed regulations notes, the additional guidance would clarify the rules in the case of eligibility for Medicaid on the basis of blindness or disability.

C. Eligibility for limited benefits

Commentators requested that the final regulations address whether eligibility for benefits with a limited scope under government programs (for example, eligibility only for family planning services under Medicaid) constitutes eligibility for minimum essential coverage. The final regulations do not address these comments because minimum essential coverage is defined in section 5000A(f). It is anticipated that regulations under section 5000A will provide that government-sponsored health benefit programs that offer only very limited benefits are not minimum essential coverage.

D. Medicare eligibility

A commentator noted that the dates in some of the examples in the proposed regulations concerning eligibility for Medicare inaccurately describe when an individual's Medicare coverage begins. The commentator also asked that the final regulations create a safe harbor for taxpayers whose Medicare coverage is delayed because they enroll during the later months of their Medicare initial enrollment period.

The final regulations revise the examples in response to this comment. The final regulations do not include the suggested Medicare safe harbor because the commentator's concerns are addressed by the general rule that an individual is eligible for minimum essential coverage on the first day of the first full month the individual may receive benefits. Additionally, as discussed earlier in this preamble, the final regulations revise the rule that an individual who fails to complete the requirements to obtain coverage is treated as eligible on the first day of the fourth month after the event establishing eligibility. Thus, individuals enrolling during the later months of their initial Medicare enrollment period will not be deemed eligible for Medicare before the expiration of the enrollment period.

E. Indian Health Service

Commentators requested that the final regulations provide that individuals eligible to receive health care from the Indian Health Service (IHS) are not eligible for government-sponsored minimum essential coverage. Section 5000A(f) defines minimum essential coverage. It does not designate the IHS as providing minimum essential coverage. Section 5000A(f)(1)(E) authorizes HHS to designate other coverage as minimum essential coverage. HHS has advised the IRS and the Treasury Department that it does not intend to designate access to the IHS as minimum essential coverage. Thus, individuals who are eligible to receive health care from the IHS will not be barred by IHS access alone from eligibility for the premium tax credit or from access to the special cost-sharing reduction for tribal members under section 1402(d) of the Affordable Care Act.

ii. Employer-Sponsored Coverage

A. Affordability

The proposed regulations provide that an eligible employer-sponsored plan is affordable for an employee and related individuals if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage (9.5 percent for taxable years beginning before January 1, 2015) of the taxpayer's household income. Commentators suggested that the affordability of coverage for related individuals

should be based on the portion of the annual premium the employee must pay for family coverage.

Under section 36B(c)(2)(C), an individual who may enroll in an eligible employer-sponsored plan may nonetheless be eligible for a premium tax credit if the employer-sponsored coverage either is unaffordable or fails to provide minimum value. Future regulations concerning employer-sponsored coverage will provide final rules on determining affordability for related individuals and proposed rules on determining minimum value.

Some commentators asked that the final rules clarify how employer contributions to health savings accounts (HSAs), and amounts made available under health reimbursement arrangements (HRAs) are treated in determining affordability. Employer contributions to an HSA would not affect the affordability of employer-sponsored coverage because HSA contributions may not be used to pay for premiums for health insurance coverage (except in limited circumstances not applicable in the context of employer-sponsored coverage). Amounts available under an HRA that may be used only to reimburse medical expenses other than the employee's required share of the cost of employer-sponsored coverage also would not affect the affordability of employer-sponsored coverage. These final regulations do not address how other HRAs are treated for purposes of determining the affordability of an employer-sponsored plan, which may be addressed further in additional published guidance, see §601.601(d)(2).

Some commentators also asked for clarification on how wellness incentive programs affect the premium affordability determination. The final regulations authorize the Commissioner to publish additional guidance, see §601.601(d)(2), to address the effect on affordability of wellness incentives that increase or decrease an employee's share of premiums. Comments are requested on types of wellness incentives, how these programs affect the affordability of eligible employer-sponsored coverage for employees and related individuals, and how incentives are earned and applied. The administrability of any rule on wellness incentives must consider the extent to which employees can be certain they will qualify for the incentives at the time they otherwise would be evaluated for eligibility for advance credit payments.

B. Affordability safe harbor

Under the proposed regulations, an employer-sponsored plan is not affordable for an employee or family member for a plan year if, when the employee or family member enrolls in a qualified health plan, an Exchange determines that the eligible employer-sponsored plan is not affordable. Individuals applying for advance credit payments are required to provide the Exchange with information on whether employer-sponsored coverage is available to them. Because an Exchange will make an affordability determination only when an individual represents that employer-sponsored coverage is available, the affordability safe harbor will not be available to a taxpayer who misrepresents to an Exchange the availability of employer-sponsored coverage. The final regulations provide that the affordability safe harbor does not apply if a taxpayer, with reckless disregard for the facts, provides incorrect information to an Exchange concerning an employee's portion of the annual premium for employer coverage. The final regulations clarify that the affordability safe harbor applies only until such time as the availability of employer-sponsored coverage changes. If new or different employer-sponsored coverage becomes available after an individual enrolls in a qualified health plan, the individual must notify the Exchange and get a new affordability determination to extend the safe harbor. As the preamble to the proposed regulation notes, 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 affordability safe harbor if the employer offers to its full-time employees affordable coverage that provides minimum value.

Under 45 CFR 155.335, Exchanges generally will conduct an annual redetermination process that will allow individuals who enroll in a qualified health plan to maintain their eligibility and enrollment for subsequent years with limited burden. This process involves notifying the individual of the information the Exchange intends to use to make a new determination of eligibility for advance credit payments and soliciting the individual to report changes. The final regulations clarify that the affordability safe harbor does not carry over to later plan years automatically as part of the redetermination process. The affordability safe harbor applies only to a plan year for which a taxpayer responds to the notification and affirmatively provides information relating to the affordability in the upcoming year of available employer-sponsored coverage, allowing an Exchange to determine that employer-sponsored coverage available to the taxpayer for that plan year is unaffordable.

C. Eligibility during a waiting period

Under section 2708 of the Public Health Service Act, employers are permitted to apply a waiting period of up to 90 days beginning when the employee is otherwise eligible for coverage under a group health plan. See Notice 2012–17, 2012–9 I.R.B. 430. The final regulations clarify that an employee or related individual is treated as not eligible for coverage under the employer's plan during a waiting period.

D. Minimum value

The proposed regulations provide that 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 is at least 60 percent. Commentators provided various recommendations for determining minimum value. Some commentators requested transition relief. Notice 2012–31, 2012–20 I.R.B. 906, solicits additional comments on potential approaches for determining minimum value. All comments will be considered in separate guidance on determining minimum value.

E. Individuals enrolled in coverage

Section 36B(c)(2)(C)(iii) and the proposed regulations provide that an individual who enrolls in an eligible employer-sponsored plan is not eligible for the premium tax credit even if the plan is unaffordable or fails to offer minimum value. Commentators asked whether an individual who enrolls in an eligible employer-sponsored plan and then terminates coverage during the plan year is treated as eligible for minimum essential coverage under

the plan for the entire plan year under this rule, even though the coverage is unaffordable or does not provide minimum value. Commentators similarly asked if individuals who enroll in continuation coverage and then disenroll from it later during the year are treated as eligible for minimum essential coverage for the entire year. In response to these comments, the final regulations clarify that an individual is treated as eligible for minimum essential coverage under an eligible employer-sponsored plan by reason of enrolling in the plan or in continuation coverage only for months the individual is enrolled in the coverage.

Commentators expressed concern that an employee may be enrolled automatically in employer-sponsored coverage and would be treated as eligible for minimum essential coverage under an employer-sponsored plan by reason of the automatic enrollment even though the plan is not affordable or does not provide minimum value. The commentators were specifically concerned about the automatic enrollment provision in section 18A of the Fair Labor Standards Act (added by section 1511 of the Affordable Care Act), which is applicable to employers with more than 200 full-time employees. (The Department of Labor, which has jurisdiction over the automatic enrollment provisions under section 18A of the Fair Labor Standards Act, does not intend to require employers to comply with the automatic enrollment provisions until after it publishes regulations and those regulations become applicable, and has indicated that the regulations will not take effect by 2014. See Notice 2012–17, Q&A–1.)

Commentators also raised concerns about the automatic enrollment of an employee in an employer-sponsored plan for other reasons, which could include automatic enrollment that a plan might provide for without regard to the automatic enrollment requirements of the Affordable Care Act, automatic enrollment that might occur because of administrative error, or automatic re-enrollment in the plan in a subsequent year. The commentators recommended allowing an employee to opt out of the employer-sponsored coverage following automatic enrollment.

In response to these comments, the final regulations provide that an employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period if the employee or related individual (1) is automatically enrolled in the plan for that plan year or other period, and (2) terminates the coverage before the later of the first day of the second full calendar month of the plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor. Thus, an individual who is automatically enrolled for a plan year or other period in coverage that is unaffordable or that does not provide minimum value and who terminates that coverage by the date specified in the preceding sentence will not be treated as eligible for minimum essential coverage under the employer-sponsored plan for the months in which the individual was automatically enrolled in the plan that are within that plan year or period. Accordingly, the individual will not be precluded by the automatic enrollment from inclusion in the taxpayer's coverage family for computing the amount of the premium tax credit for those months.

iii. Nondependent Eligibility for Minimum Essential Coverage

Commentators asked whether individuals who may enroll in an eligible employer-sponsored plan based on their relationship to an employee but who are not tax dependents (for example, a 25-year old child or a domestic partner of the employee) are treated as eligible for minimum essential coverage under the plan. In response to these comments, the final regulations provide that an individual who may enroll in minimum essential coverage because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction under section 151, is treated as eligible for minimum essential coverage under the coverage only for months that the related individual is enrolled in the coverage. This change reflects the fact that the related individual is a member of a different family with different household income for purposes of the premium tax credit. Furthermore, a person who may not claim a related individual as a dependent is not responsible for the section 5000A penalty for the related individual who does not receive coverage. Thus, the final regulations ensure that coverage available through another person does not create an obstacle to a related individual claiming a premium tax credit.

3. *Computing the Premium Tax Credit*

a. *Definition of coverage month*

Section 36B(c)(2)(A)(ii) and the proposed regulations provide that a month is a coverage month for an individual only if the individual is enrolled in a qualified health plan and is not eligible for other minimum essential coverage on the first day of the month, and the premiums are paid by the taxpayer or through advance credit payments.

Consistent with the proposed regulations, the final regulations provide that an individual must be enrolled in a qualified health plan as of the first day of the month for a month to be a coverage month. However, instead of testing whether the individual is eligible for other minimum essential coverage as of the first day of the month, the final regulations provide that an individual may have a coverage month as long as there is at least one day of the month when the individual is not eligible for other minimum essential coverage. The final regulations also clarify that a month is not a coverage month for a taxpayer if the taxpayer's share of premiums is not paid in full by the unextended due date for filing the taxpayer's income tax return for the taxable year.

b. *Third-party payments*

Under the proposed regulations, premiums another person pays for coverage of the taxpayer or a member of the taxpayer's family for a month are treated as paid by the taxpayer solely for purposes of the month qualifying as a coverage month. Commentators asked for confirmation that an Indian tribe may pay premiums on behalf of a tribal member. The final regulations add an example illustrating that premiums paid for a taxpayer by an Indian tribe are treated as paid by the taxpayer under the coverage month rule.

c. *Adjusted monthly premium*

Under section 36B(b)(3)(C), the adjusted monthly premium is the premium an issuer would charge to cover all members of a taxpayer's coverage family, adjusted

only for age. A commentator noted that the definition of adjusted monthly premium in the proposed regulations does not include the statutory qualification that, in the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium is determined without regard to any premium discount or rebate under the project. The final regulations revise the definition of adjusted monthly premium in accordance with this comment and clarify that the premium may not be adjusted for tobacco use, see section 36B(b)(3)(C).

d. *Applicable benchmark plan*

i. In General

Under section 36B(b)(3)(B), a taxpayer's premium tax credit is computed based on the premium for the applicable second lowest cost silver plan in the rating area where the taxpayer resides and offered by the Exchange where the taxpayer enrolls in a qualified health plan. For simplicity, the proposed regulations refer to this plan as the applicable benchmark plan.

Section 36B(b)(3)(B)(ii) describes the "applicable" benchmark plan as providing self-only or family coverage. The proposed regulations define family coverage as insurance that covers more than one individual. The proposed regulations further provide that a taxpayer's "applicable" benchmark plan is the benchmark plan that "applies" to the members of the taxpayer's coverage family. The proposed regulations define the coverage family, in general, as the members of the taxpayer's family (the individuals for whom the taxpayer properly claims a personal exemption deduction under section 151) who are not eligible for other minimum essential coverage. The final regulations clarify that the coverage family includes only those individuals in the taxpayer's family who are not eligible for other minimum essential coverage and enroll in a qualified health plan.

For purposes of determining the benchmark plan that "applies" to a coverage family, the proposed regulations provide that if an Exchange offers categories of family coverage (such as coverage for two adults or coverage for one adult plus children), 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. The final regulations delete the reference to coverage categories. The final Exchange rules promulgated by HHS removed references to rating categories, which are a parallel concept to coverage categories. The final regulations provide that the applicable benchmark plan for family coverage is the plan that applies to the members of the taxpayer's coverage family.

Commentators requested clarification on how the applicable benchmark plan would be determined for a qualified health plan that covers children only. The final regulations provide an example in response to this comment.

ii. Families Not Covered by One Applicable Benchmark Plan

The proposed regulations provide that the premium for the applicable benchmark plan is the sum of the premiums for the applicable benchmark plans that cover components of the taxpayer's coverage family if a single benchmark plan would not cover the family, for example because members live in different rating areas. The final regulations provide that, if there is at least one silver level plan offered on an Exchange that does not cover all members of a taxpayer's coverage family under one policy and premium, for example because of nontraditional relationships within the family, the premium for the applicable benchmark plan is the single premium or the combination of premiums that is the second lowest cost silver option for covering the entire family. The final regulations reserve rules for determining the applicable benchmark plan for families with members residing in different locations.

Commentators stated that the final regulations should allow domestic partners and other two-adult groups to use a family benchmark plan to compute their premium tax credit if the Exchange allows both adults to be covered by the same qualified health plan. The final regulations do not adopt this suggestion. If the adults constitute two separate households for Federal tax purposes, section 36B requires a separate credit computation for each household that includes only those individuals for whom each taxpayer claims a personal exemption deduction under section 151.

iii. Plans Closed to Enrollment

The proposed regulations provide that, in general, an applicable benchmark plan is the second lowest cost silver plan offered through the Exchange at the time a taxpayer or family member enrolls. However, a plan does not cease to be a taxpayer's applicable benchmark plan for that enrollment period because the plan or a lower cost plan closes to enrollment during the taxable year. Thus, a plan may continue to be an applicable benchmark plan if it closes to enrollment after a taxpayer enrolls in a qualified health plan, but it is disregarded in determining the applicable benchmark plan if it is closed to enrollment at the time the taxpayer enrolls.

A commentator requested that the final regulations exclude certain qualified health plans open to enrollment only to certain individuals when determining which plan constitutes a taxpayer's applicable benchmark plan. The final regulations clarify that a plan is taken into account in determining the taxpayer's applicable benchmark plan only if it is open to enrollment to one or more members of a taxpayer's coverage family.

iv. Changes Affecting Applicable Benchmark Plan

Commentators asked whether a taxpayer's applicable benchmark plan is locked in at enrollment and whether the benchmark plan could change during the year if a plan is decertified or if members of the taxpayer's family leave the plan. The proposed regulations provide that a taxpayer's applicable benchmark plan may change from month to month if changes in the taxpayer's coverage family occur (for example, if a family member becomes eligible or ineligible for minimum essential coverage during the taxable year). The proposed regulations also provide that a taxpayer's applicable benchmark plan 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 year. The final regulations adopt the proposed regulations without change.

e. *Combining qualified health plan premiums with premiums for other coverage*

Section 36B(b) and the proposed regulations provide that the premium tax credit is the lesser of (1) the premiums for the qualified health plan or plans in which a taxpayer or family member enrolls, or (2) the difference between the premium for a benchmark qualified health plan and the amount of the premium that the taxpayer would be required to pay if the taxpayer purchased the benchmark plan (the taxpayer's contribution amount). Commentators suggested that the final regulations allow taxpayers to determine the premium tax credit by combining the premiums for one or more qualified health plans with premiums a taxpayer pays for other minimum essential coverage (particularly premiums for coverage under CHIP). Under the rule suggested by the commentators, the taxpayer's contribution amount would be reduced by the amount of the family's other premiums to ensure that a family could afford the combined premiums for qualified health plan coverage and CHIP or other coverage.

Under section 36B(b)(2), the premium tax credit is computed by taking into account only the premiums for qualified health plans. Thus, the credit may not be increased for premiums for other minimum essential coverage.

f. *Pediatric dental coverage*

Under section 36B(b)(3)(E), if an individual enrolls in both a qualified health plan and a dental plan, the portion of the premium for the dental plan properly allocable to pediatric dental benefits that are essential health benefits is treated as premiums payable for a qualified health plan for purposes of determining the monthly premium. The proposed regulations requested comments on methods for determining the amount of the premium properly allocable to pediatric dental benefits.

Commentators requested that the final regulations use a methodology that reflects the true costs of medical and dental care for children. Other commentators recommended that the Federal government split the value of the premium tax credit on a basis proportionate to the premium for the pediatric service in the dental plan and the qualified health plan premium. Some commentators requested a simple formula for allocating a taxpayer's dental benefits premium to pediatric dental care. A commentator requested a safe harbor permitting dental insurance carriers to use a reasonable method based on sound actuarial practice.

The final regulations provide that the portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits is determined under guidance issued by HHS. Under the final HHS Exchange regulations at 45 CFR 156.210, a qualified health plan issuer that offers a standalone dental plan is required to provide information on the plan's rates to the Exchange each year. It is anticipated that future HHS guidance will address how this required reporting on rates will include reporting on the portion of the premium allocable to pediatric dental coverage.

g. *Families with individuals not lawfully present*

Section 36B(e)(1)(B) describes a method for determining the FPL percentage for families that include an individual not lawfully present (the statutory method) and allows a comparable method that reaches the same results to be prescribed by regulations. Commentators suggested that the final regulations provide a comparable method based on the Medicaid rules for income and family size determinations.

The commentators' suggested method may not reach the same result as the statutory method. Thus, the final regulations do not adopt this suggestion. The final regulations provide that the Commissioner may provide a comparable method in additional published guidance, see §601.601(d)(2).

4. *Reconciling the Credit and Advance Credit Payments*

a. *Months for which an issuer does not provide coverage*

Section 1412(c)(2)(B) of the Affordable Care Act provides that an issuer receiving an advance credit payment must reduce the premiums charged to the insured for the period covered by the advance payment but may terminate coverage if the insured fails to pay premiums for a 3-month period. The final HHS Exchange regulations describe the operation of this grace period in more detail. Under the retroactive termination rule, if a taxpayer does not pay premiums in full for 3 months, the issuer must terminate coverage retroactive to the end of the first of those months and will be required to return any advance payments received for any terminated coverage months. These final regulations clarify that a taxpayer does not have an advance credit payment for a month in which the issuer of the qualified health plan does not provide coverage and will not be required to reconcile payments for those months. The taxpayer will, however, have to reconcile the payment for the first month of the grace period. If the taxpayer has not paid the taxpayer's share of the premium for that month by the unextended due date for filing the return, the first month is not a coverage month, and the taxpayer is not eligible for the premium tax credit for that month.

b. *Changes in circumstances*

Section 36B(f) provides that a taxpayer must reconcile on the taxpayer's income tax return for the taxable year the premium tax credit allowed under section 36B with the advance payments paid during the course of the taxable year and must pay the amount of any excess advance payments as additional tax. For taxpayers with household income below 400 percent of the FPL, the amount of additional tax liability the taxpayer must repay is capped.

Commentators requested that the final regulations include rules to mitigate the effects of the requirement to repay excess advance payments. Commentators suggested that the final regulations adopt a safe harbor for individuals and families who can demonstrate that they accurately reported any changes in income or family size to the Exchange and that their advance payments were properly computed based on the information available at the time the payments were made. Commentators suggested that taxpayers who experience changes in circumstances during the year, including taxpayers whose household income for the taxable year exceeds 400 percent of the FPL, should be allowed to prorate the repayment limitations based on the portion of the year the taxpayer receives advance payments. Other commentators asked that taxpayers who would experience a hardship as a result of repaying

excess advance payments be exempt from the repayment requirement or that the IRS should disregard changes that cause income to slightly exceed 400 percent of the FPL. Commentators also suggested that taxpayers be allowed to compute their premium tax credit using the largest family size of the household during the year rather than the family size reported on the tax return.

The statute sets forth clear rules for reconciling advance credit payments, which are not consistent with the suggestions made by the commentators. Accordingly, the final regulations do not adopt these comments.

Commentators suggested that the IRS should offer automatic payment plans for taxpayers who have an additional tax liability and should not impose interest or penalties on this additional tax liability repaid through the payment plan. Although these comments are beyond the scope of these final regulations, the IRS will consider possible avenues of administrative relief in appropriate cases for taxpayers who have additional tax liability as a result of excess advance payments.

c. *Changes in filing status*

i. Taxpayers Who Marry During the Taxable Year

The proposed regulations provide that, like other taxpayers, newly-married taxpayers compute their premium tax credit using family size and household income as reported on their tax return and the appropriate applicable benchmark plan for each coverage month regardless of whether the taxpayers were married or single during the month. The proposed regulations request comments on alternative credit computations for taxpayers who receive advance payments, marry during the year, and owe additional tax, even if the Exchange accurately projects each spouse's separate income.

Some commentators suggested an alternative computation that computes the credit for the single months separately for each spouse as if each taxpayer's annual income was one-half of the actual household income for the year. For the married months, the credit would be computed using actual household income for the year. The premium tax credit would be the sum of the credits computed for the single months and the married months. This computation generally results in a smaller amount of excess advance payments compared to the amount computed under the proposed regulations.

The final regulations adopt the alternative credit computation suggested by the commentators as an option for taxpayers who marry during the taxable year. Under this alternative method, the credit for the single months is computed separately for each spouse as if each taxpayer's annual income was one-half of the actual household income for the year, the credit for the married months is computed using actual household income for the year, and the premium tax credit is the sum of the credits computed for the single months and the married months. However, to avoid allowing taxpayers an increased amount of additional premium tax credit resulting from marriage, the final regulations cap any additional premium tax credit allowed to a taxpayer under this alternative computation method at the amount of additional credit that results from computing the credit under the general rule.

Commentators requested that the final regulations allow a year-of-marriage waiver on repaying excess advance payments. The final regulations do not adopt these comments as these rules would create unwarranted benefits, for example in cases of taxpayers who marry during the year and owe additional tax because their income is significantly higher than what the Exchange projected.

ii. Taxpayers Whose Marital Status Changes from Married to Single During the Taxable Year

The proposed regulations provide that taxpayers who are married to each other at the beginning but not at the end of 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. The proposed regulations permit the allocation to be made in any proportion, but if the taxpayers cannot agree on a proportion, these items are allocated 50 percent to each taxpayer.

Commentators opined that the final regulations should provide for allocating these items to each taxpayer in proportion to each taxpayer's household income. The final regulations do not adopt this suggestion as it would require divorced taxpayers to exchange income information or require the IRS to associate each taxpayer's return with the other. Divorced taxpayers may allocate the premium for the applicable benchmark plan, the premium for the plan in which the taxpayers enroll, and the advance credit payments in proportion to household income under the final regulations if they choose.

iii. Married Taxpayers Filing Separately

Section 36B(c)(1)(C) provides that married taxpayers who do not file a joint return are not applicable taxpayers and are not allowed a premium tax credit. Accordingly, married taxpayers who receive advance credit payments but do not file a joint return must repay the advance credit payments. The advance credit payments must be allocated equally to each taxpayer for purposes of determining the amount of excess advance payments. The final regulations clarify that this equal allocation also applies if one spouse is treated as unmarried under section 7703(b) (and may, for example, properly claim the premium tax credit on a return filed as head of household).

The proposed regulations requested comments on special rules for taxpayers who receive advance payments but face challenges in meeting the joint return requirement, for example because of the incarceration of a spouse, domestic abuse, or a pending divorce.

Numerous commentators stated that the final regulations should provide special rules allowing these spouses to file separate returns and claim the premium tax credit. Commentators suggested that abandoned spouses also warrant an exception. Other commentators noted that other married taxpayers may face challenges in filing a joint return and asked for a hardship exemption from the joint filing requirement.

Commentators suggested that taxpayers should be able to certify on the premium tax credit form that they meet the criteria for an exemption from the joint filing requirement. One commentator suggested granting an exception in case of domestic

violence for a taxpayer who has or during the taxable year had an order of protection.

Some commentators, noting that many of these situations are not resolved in a single taxable year, requested a three-year exception to the joint filing requirement.

The final regulations do not provide special rules allowing married taxpayers to claim the premium tax credit on separate returns. However, the IRS and the Treasury Department intend to propose additional regulations regarding eligibility for the premium tax credit to address circumstances in which domestic abuse, abandonment, or similar circumstances create obstacles to the ability of taxpayers to file joint returns. Comments are requested on the documentation that a taxpayer could provide to establish that he or she cannot file a joint return because of the domestic abuse, abandonment, or other similar circumstances, on what treatment should be accorded the other spouse if he or she does not file with documentation supporting an exception, and the need for anti-abuse rules.

5. *Information Reporting*

Commentators requested that the final regulations require an Exchange, in reporting information under section 36B(f)(3), to strictly define and limit the use and disclosure of immigration status information for any purpose other than ensuring efficient operation of the Exchange and prohibit the transfer of immigration status information from the Exchange to the IRS. The final regulations do not include a rule responding to these comments because the IRS does not require information on immigration status of any individual in order to administer the premium tax credit and will not obtain this information. The Exchange will verify that an individual is a citizen or lawfully present and eligible to enroll in coverage through the Exchange.

The proposed regulations provide that the IRS will provide rules on the time and manner of information reporting by Exchanges in additional published guidance, see §601.601(d)(2). Commentators requested that the final regulations provide information on the time and manner of information reporting by Exchanges. A commentator suggested that the information returns should be provided to taxpayers by December 31. Another commentator suggested that the annual information return should report the cost of the applicable benchmark plan on the first day of each month. The final regulations defer rules on the time for information reporting by Exchanges to additional regulations, which are expected to provide for monthly reporting by Exchanges to the IRS and an annual report to the IRS and the taxpayer due by January 31.

6. *American Indians/Alaska Natives*

Commentators asked that the final regulations provide special provisions for American Indians and Alaska Natives, for example that they be treated as eligible for employer-sponsored minimum essential coverage only if they are enrolled in the coverage, that they should not be required to pay any premiums for a qualified health plan, and that they be exempted from reconciliation. The IRS and HHS have conducted several tribal consultations on these and other issues under the proposed regulations. The final regulations do not adopt these suggestions, as they are inconsistent with the statute.

7. *Effective/Applicability Date*

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

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. Section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and, because the regulations do not impose a collection of information requirement on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking that preceded these final regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business, and no comments were received.

Comments

Written (including electronic) comments must be received by August 21, 2012. Comments should be submitted to Internal Revenue Service, CC:PA:LPD:PR (REG–131491–10), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044, or electronically to *www.regulations.gov* (IRS REG–131491–10). Alternatively, comments may be hand delivered between the hours of 8:00 a.m. and 4:00 p.m. Monday to Friday to CC:PA:LPD:PR (REG–131491–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, D.C. All comments will be available for public inspection and copying.

Drafting Information

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

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Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 602 are amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by adding an entry 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.

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(m) Family coverage.
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§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)), the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112–10 (125 Stat. 38 (2011)), and the 3% Withholding Repeal and Job Creation Act, Public Law 112–56 (125 Stat. 711 (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 may include individuals who are not subject to or are exempt from the penalty under section 5000A for failing to maintain minimum essential coverage.

(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 a return of tax imposed by section 1 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—

(i) Amounts excluded from gross income under section 911;

(ii) Tax-exempt interest the taxpayer receives or accrues during the taxable year; and

(iii) Social security benefits (within the meaning of section 86(d)) not included in gross income under section 86.

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

(g) *Lawfully present.* Lawfully present has the same meaning as in 45 CFR 155.20.

(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. If a taxpayer's primary residence changes during a taxable year from one state to a state with different Federal poverty guidelines or married taxpayers reside in separate states with different Federal poverty guidelines (for example, Alaska or Hawaii and another state), the Federal poverty line that applies for purposes of section 36B and the associated regulations is the higher Federal poverty guideline (resulting in a lower percentage of the Federal poverty line for the taxpayers' household income and family size).

(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.* [Reserved]

(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 one or more members of the applicable taxpayer's family (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) is not eligible to enroll in 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 lawfully present 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*. 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) as of the first day of the first full month the individual may receive benefits under the program, subject to the limitation in paragraph (c)(2)(ii) of this section. The Commissioner may define eligibility for specific government-sponsored programs further in additional published guidance, see §601.601(d)(2) of this chapter.

(ii) *Obligation to complete administrative requirements to obtain coverage*. An individual who meets the criteria for eligibility for government-sponsored minimum essential coverage must complete the requirements necessary to receive benefits. An individual who fails by the last day of the third full calendar month following the event that establishes eligibility under paragraph (c)(2)(i) of this section to complete the requirements to obtain government-sponsored minimum essential coverage (other than a veteran's health care program) is treated as eligible for government-sponsored minimum essential coverage as of the first day of the fourth calendar month following the event that establishes eligibility.

(iii) *Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, U.S.C.* An individual is eligible for minimum essential coverage under a health care program under chapter 17 or 18 of Title 38, U.S.C. only if the individual is enrolled in a health care program under chapter 17 or 18 of Title 38, U.S.C. identified as minimum essential coverage in regulations issued under section 5000A.

(iv) *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.

(v) *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, when the individual enrolls in the qualified health plan, an Exchange determines or considers (within the meaning of 45 CFR 155.302(b)) the individual to be not eligible for Medicaid or CHIP.

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

Example 1. Delay in coverage effectiveness. On April 10, 2015, Taxpayer D applies for coverage under a government-sponsored health care program. D's application is approved on July 12, 2015, but her coverage is not effective until September 1, 2015. Under paragraph (c)(2)(i) of this section, D is eligible for government-sponsored minimum essential coverage on September 1, 2015.

Example 2. Time of eligibility. Taxpayer E turns 65 on June 3, 2015, and becomes eligible for Medicare. Under section 5000A(f)(1)(A)(i), Medicare is minimum essential coverage. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare in September, which is the last month of E's initial enrollment period. Thus, E may receive Medicare benefits on December 1, 2015. Because E completed the requirements necessary to receive Medicare benefits by the last day of the third full calendar month after the event that establishes E's eligibility (E turning 65), under paragraph (c)(2)(i) and (c)(2)(ii) of this section E is eligible for government-sponsored minimum essential coverage on December 1, 2015, 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 during E's initial enrollment period. E is treated as eligible for government-sponsored minimum essential coverage under paragraph (c)(2)(ii) of this section as of October 1, 2015, the first day of the fourth month following the event that establishes E's eligibility (E turning 65).

Example 4. Retroactive effect of eligibility. In November 2014, Taxpayer F enrolls in a qualified health plan for 2015 and receives advance credit payments. F loses her part-time employment and on April 10, 2015 applies for coverage under the Medicaid program. F's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (c)(2)(iv) of this section, F 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 G applies through the Exchange to enroll in health coverage for 2015. The Exchange determines that G is not eligible for Medicaid and estimates that G's household income will be 140 percent of the Federal poverty line for G's family size for purposes of determining advance credit payments. G enrolls in a qualified health plan

and begins receiving advance credit payments. G experiences a reduction in household income during the year and his household income for 2015 is 130 percent of the Federal poverty line (within the Medicaid income threshold). However, under paragraph (c)(2)(v) of this section, G 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 G returns to the Exchange in July 2015 and the Exchange determines that G is eligible for Medicaid. Medicaid approves G for coverage and the Exchange discontinues G's advance credit payments effective August 1. Under paragraphs (c)(2)(iv) and (c)(2)(v) of this section, G is treated as not eligible for Medicaid for the months when G is covered by a qualified health plan. G is eligible for government-sponsored minimum essential coverage for the months after G is approved for Medicaid and can receive benefits, 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 months during a plan year*—(A) *Failure to enroll in plan.* An employee or related individual may be eligible for minimum essential coverage under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period.

(B) *Waiting periods.* An employee or related individual is not eligible for minimum essential coverage under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.

(C) *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 under X's plan for the months that B is enrolled in the qualified health plan during X's plan year (January through September 2015).

(iv) *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 for months that the individual is enrolled in the coverage.

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

(*2*) *Affordability for related individual.* [Reserved]

(*3*) *Employee safe harbor.* An employer-sponsored plan is 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 for that plan year. This paragraph (c)(3)(v)(A)(*3*) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information on affordability. This paragraph (c)(3)(v)(A)(*3*) does not apply for an individual who, with reckless disregard for the facts, provides incorrect information to an Exchange concerning the portion of the annual premium for coverage for the employee or related individual under the plan.

(*4*) *Wellness incentives and employer contributions to health reimbursement arrangements.* The Commissioner may provide rules in published guidance, see §601.601(d)(2) of this chapter, for determining how wellness incentives and amounts made available under a health reimbursement arrangement are treated in determining the affordability of eligible employer-sponsored coverage under this paragraph (c)(3)(v).

(B) *Affordability for part-year period.* Affordability under paragraph (c)(3)(v)(A) of this section is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different taxable years of an applicable taxpayer (a part-year period). An eligible employer-sponsored plan is affordable for a part-year period if the employee's annualized required contribution for self-only coverage under the plan for the part-year period does not exceed the required contribution percentage of the applicable taxpayer's household income for the taxable year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable taxpayer's taxable year. Only full calendar months are included in the computation under this paragraph (c)(3)(v)(B).

(C) *Required contribution percentage.* The required contribution percentage is 9.5 percent. The percentage may be adjusted in published guidance, 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.

(D) *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. [Reserved]

Example 3. Determination of unaffordability at enrollment. (i) Taxpayer D is an employee of Employer X. In November 2013 the Exchange for 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 D's 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)(*3*) of this section, X's plan is not affordable for D and D is not eligible for minimum essential coverage under X's plan 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 for 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)(*3*) of this section, X's plan is not affordable for D and D is 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. No affordability information affirmatively provided for annual redetermination. (i) The facts are the same as in *Example 3*, except the Exchange redetermines D's eligibility for advance credit payments for 2015. D does not affirmatively provide the Exchange with current information regarding affordability and the Exchange determines that D's coverage is not affordable for 2015 and approves advance credit payments based on information from the previous enrollment period. In 2015, D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Because D does not respond to the Exchange notification and the Exchange makes an affordability determination based on information from an earlier year, the employee safe harbor in paragraph (c)(3)(v)(A)(*3*) of this section does not apply. D's required contribution for 2015 does not exceed 9.5 percent of D's household income. Thus, X's plan is affordable for D for 2015 and D is eligible for minimum essential coverage for all months in 2015.

Example 6. Determination of unaffordability for part of plan year (part-year period). (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 for E's rating area projects 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) Under paragraph (c)(3)(v)(B) of this section, 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)(*3*) of this section, X's plan is 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 7. 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 enroll in X's plan during X's open season but enrolls in a qualified health plan for September through December 2014. F does not request advance credit payments and does not ask the Exchange for his rating area to determine whether X's coverage is affordable for F. 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) under paragraph (c)(3)(v)(B) of this section. 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 approve advance credit payments or 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 8. Coverage unaffordable at year end. Taxpayer G is employed by Employer X. In November 2014, the Exchange for 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 under X's plan for 2015.

(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 to the employee under the plan (as determined under guidance 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*. Except as provided in paragraph (c)(3)(vii)(B) of this section, the requirements of affordability and minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.

(B) *Automatic enrollment*. An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.

(C) *Examples*. The following examples illustrate the provisions of this paragraph (c)(3)(vii):

Example 1. Taxpayer H is employed by Employer X in 2014. H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.

Example 2. The facts are the same as in *Example 1*, except that H terminates plan coverage on June 30, 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage under X's plan for January through June 2014 but is not eligible for minimum essential coverage under X's plan for July through December 2014.

Example 3. The facts are the same as in *Example 1*, except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (c)(3)(vii)(B) of this section, H is not eligible for minimum essential coverage under X's plan for January 2015.

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

§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 enroll in a qualified health plan and are not eligible for minimum essential coverage (other than coverage in the individual market).

(c) *Coverage month*—(1) *In general*. A month is a coverage month for an individual if—

(i) As of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange;

(ii) The taxpayer pays the taxpayer's share of the premium for the individual's coverage under the plan for the month by the unextended due date for filing the taxpayer's income tax return for that taxable year, or the full premium for the month is paid by advance credit payments; and

(iii) The individual is not eligible for the full calendar month 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 a 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):

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. M pays M's share of the premiums. 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 terminates enrollment in 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. N pays all premiums not covered by advance credit payments.

(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 portion of T's qualified health plan premiums not covered by advance credit payments.

(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 and not eligible for other minimum essential coverage are coverage months under paragraph (c)(1) of this section in computing P's premium tax credit under paragraph (a) of this section.

Example 4. Q, an American Indian, enrolls in a qualified health plan for 2014. Q's tribe pays the portion of Q's qualified health plan premiums not covered by advance credit payments. Under paragraph (c)(2) of this section, the premiums that Q's tribe pays for Q are treated as paid by Q. Thus, the months when Q is covered by a qualified health plan and not eligible for other minimum essential coverage are coverage months under paragraph (c)(1) of this section in computing Q'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 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 issuer 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). The adjusted monthly premium is determined without regard to any premium discount or rebate under the wellness discount demonstration project under section 2705(d) of the Public Health Service Act (42 U.S.C. 300gg–4(d)) and may not include any adjustments for tobacco use.

(f) *Applicable benchmark plan*—(1) *In general*. Except as otherwise provided in this paragraph (f), the applicable benchmark plan for each coverage month is the second lowest cost silver plan (as described in section 1302(d)(1)(B) of the Affordable Care Act (42 U.S.C. 18022(d)(1)(B))) offered through the Exchange for the rating area where the taxpayer resides for—

(i) Self-only coverage for a taxpayer—

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

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

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

(ii) Family coverage for all other taxpayers.

(2) *Family coverage*. The applicable benchmark plan for family coverage is the second lowest cost silver plan that applies to the members of the taxpayer's coverage

family (such as a plan covering two adults if the members of a taxpayer's coverage family are two adults).

(3) *Silver level plan not covering a taxpayer's family*. If one or more silver level plans for family coverage offered through an Exchange do not cover all members of a taxpayer's coverage family under one policy (for example, because of the relationships within the family), the premium for the applicable benchmark plan determined under paragraphs (f)(1) and (f)(2) of this section may be the premium for a single policy or for more than one policy, whichever is the second lowest cost silver option.

(4) *Family members residing at different locations*. [Reserved]

(5) *Plan closed to enrollment*. A qualified health plan that is not open to enrollment by a taxpayer or family member at the time the taxpayer or family member enrolls in a qualified health plan is disregarded in determining the applicable benchmark plan.

(6) *Benchmark plan terminates or closes to enrollment during the year*. 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.

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

Example 1. Single taxpayer enrolls. Taxpayer M is single, has no dependents and enrolls in a qualified health plan. Under paragraph (f)(1)(i) of this section, M's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for M.

Example 2. Family enrolls. The facts are the same as in *Example 1*, except that M, her spouse N, and their dependent enroll in a qualified health plan. Under paragraphs (f)(1)(ii) and (f)(2) of this section, M's and N's applicable benchmark plan is the second lowest cost silver plan covering M, N, and their dependent.

Example 3. Single taxpayer enrolls with nondependent. Taxpayer O is single and resides with his daughter, K, but may not claim K as a dependent. O purchases family coverage for himself and K. Under paragraphs (f)(1)(i)(A) and (f)(1)(i)(C) of this section, O's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for O. However, K may qualify for a premium tax credit if K is otherwise eligible. See paragraph (h) of this section.

Example 4. Single taxpayer enrolls with dependent and nondependent. The facts are the same as in *Example 3*, except that O also resides with his teenage son, L, and claims L as a dependent. O purchases family coverage for himself, K, and L. Under paragraphs (f)(1)(ii) and (f)(2) of this section, O's applicable benchmark plan is the second lowest cost silver plan covering O and L.

Example 5. Children only enroll. The facts are the same as in *Example 4*, except that O enrolls only K and L in the coverage. Under paragraph (f)(1)(i)(C) of this section, O's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for L.

Example 6. Applicable benchmark plan unrelated to coverage purchased. Taxpayers P and Q, who are married, reside with Q's two teenage daughters, M and N, whom they claim as dependents. P and Q purchase self-only coverage for P and family coverage for Q, M, and N. Under paragraphs (f)(1)(ii) and (f)(2) of this section, P's and Q's applicable benchmark plan is the second lowest cost silver plan covering P, Q, M, and N.

Example 7. Change in coverage family. Taxpayer R is single and has no dependents when she enrolls in a qualified health plan for 2014. On August 1, 2014, R has a child, O, whom she claims as a dependent for 2014. R enrolls in a qualified health plan covering R and O effective August 1. Under paragraph (f)(1)(i) of this section, R's applicable benchmark plan for January through July is the second lowest cost silver plan providing self-only coverage for R. Under paragraphs (f)(1)(ii) and (f)(2) of this section, R's applicable benchmark plan for the months August through December is the second lowest cost silver plan covering R and O.

Example 8. Minimum essential coverage for some coverage months. Taxpayer S claims his daughter, P, as a dependent. S and P enroll in a qualified health plan for 2014. S, but not P, 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 P and January through August are coverage months for S. 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, S's applicable benchmark plan for January through August is the second lowest cost silver plan under paragraphs (f)(1)(ii) and (f)(2) of this section covering S and P. Under paragraph (f)(1)(i)(C) of this section, S's applicable benchmark plan for September through December is the second lowest cost silver plan providing self-only coverage for P.

Example 9. Family member eligible for minimum essential coverage for the taxable year. The facts are the same as in *Example 8*, except that S is not eligible for government-sponsored minimum essential coverage for any months and P is eligible for government-sponsored minimum essential coverage for the entire year. Under paragraph (f)(1)(i)(C) of this section, S's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for S.

Example 10. Qualified health plans not covering certain families. (i) Taxpayers V and W are married and live with W's mother, K, whom they claim as a dependent. The Exchange for their rating area offers self-only and family coverage at the silver level through Issuers A, B, and C, who each offer only one silver level plan. Issuers A and B respectively charge V and W a monthly premium of $900 and $700 for family coverage, but do not allow individuals to enroll a parent in family coverage. Issuers A and B respectively charge $600 and $400 for self-only coverage for K. Issuer C offers a qualified health plan that provides family coverage for V, W, and K under one policy for a $1,200 monthly premium. Thus, the Exchange offers the following silver level options for covering V's and W's coverage family:

Issuer A: $1,500 for premiums for two policies ($900 for V and W, $600 for K)
Issuer B: $1,100 for premiums for two policies ($700 for V and W, $400 for K)
Issuer C: $1,200 for premiums for one policy ($1,200 for V, W, and K)

(ii) Because some silver level qualified health plans for family coverage offered on the Exchange do not cover all members of their coverage family under one policy, under paragraph (f)(3) of this section, the premium for V's and W's applicable benchmark plan may be the premium for a single policy or for more than one policy. The coverage offered by Issuer C is the second lowest cost silver level option for covering V's and W's family. The premium for their applicable benchmark plan is the premium for the Issuer C coverage.

Example 11. (i) The facts are the same as in *Example 10*, except that Issuer B covers V, W, and K under one policy for a premium of $1,100, and Issuer C does not allow individuals to enroll parents in family coverage. Issuer C charges a monthly premium of $700 for family coverage for V and W and a monthly premium of $500 for self-only coverage for K. Thus, the Exchange offers the following silver level options for covering V's and W's coverage family:

Issuer A: $1,500 for premiums for two policies ($900 for V and W, $600 for K)
Issuer B: $1,100 for premiums for one policy ($1,100 for V, W, and K)
Issuer C: $1,200 for premiums for two policies ($700 for V and W, $500 for K)

(ii) The coverage offered by Issuer C is the second lowest cost silver level option for covering V's and W's family. The premium for their applicable benchmark plan is the premiums for the two policies available through Issuer C.

Example 12. Family members residing in different locations. [Reserved]

Example 13. Qualified health plan closed to enrollment. Taxpayer Y has two dependents, R and S. Y, R, and S enroll in a qualified health plan. The Exchange for the rating area where the family resides offers silver level plans J, K, L, and M, which are the first, second, third, and fourth lowest cost silver plans covering Y's family. When Y's family enrolls, Plan J is closed to enrollment. Under paragraph (f)(5) of this section, Plan J is disregarded in determining Y's applicable benchmark plan, and Plan L is Y's applicable benchmark plan.

Example 14. Benchmark plan closes to new enrollees during the year. (i) 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 the two adults in each coverage family offered through the Exchange. The X and Y families each enroll in a qualified health plan that is not the applicable benchmark plan (Plan 4) in November during the annual open enrollment period. Plan 2 closes to new enrollees the following June. Thus, on July 1, Plan 3 is the second lowest cost silver plan available to new enrollees through the Exchange. The Z family enrolls in a qualified health plan in July.

(ii) Under paragraphs (f)(1), (f)(2), and (f)(6) 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 open to enrollment through the Exchange when the Z family enrolls.

Example 15. Benchmark plan terminates for all enrollees during the year. The facts are the same as in *Example 14*, except that Plan 2 terminates for all enrollees on June 30. Under paragraphs (f)(1), (f)(2), and (f)(6) 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 required share 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, 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 Federal poverty line 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 X 1.75	= .35
6.3 + .35	= 6.65.

(h) *Plan covering more than one family*—(1) *In general*. If a qualified health plan covers more than one family under a single policy, 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 applicable benchmark plan.

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

Example. (i) Taxpayers A and B enroll in a single policy under a 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 additional 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 covering only A and A's dependents is $12,000 and the premium for the second lowest cost silver plan providing self-only coverage to B 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 x $12,000/$18,000) and the portion allocated to B is $5,000 ($15,000 x $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 guidance issued by the Secretary of Health and Human Services. See section 36B(b)(3)(D).

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

Example 1. (i) Taxpayer B enrolls in a qualified health plan that provides benefits in addition to the essential health benefits the plan must provide (additional benefits). The monthly premium for the plan in which B enrolls is $385 (Amount 1), of which $35 is allocable to the additional benefits. The premium for B's applicable benchmark plan is $440, of which $40 is allocable to the additional benefits. The excess of the premium for B's applicable benchmark plan over B's $60 contribution amount (which is the product of B's household income and the applicable percentage) is $380 per month (Amount 2).

(ii) Under this paragraph (j), the premium for the qualified health plan in which B enrolls and the applicable benchmark premium each is reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, Amount 1 is reduced to $350 ($385 - $35), the premium for B's applicable benchmark plan is reduced to $400 ($440 - $40), and Amount 2 is reduced to $340 ($400 less $60). B's premium assistance amount for a coverage month is $340, the lesser of Amount 1 and Amount 2.

Example 2. (i) The facts are the same as in *Example 1*, except that B's applicable benchmark plan provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under paragraph (j) of this section, only the amount of the monthly premium for the plan in which B enrolls is reduced by the portion of the premium that is allocable to the additional benefits provided under that plan, and Amount 1 is $350 ($385 - $35). The premium for B's applicable benchmark plan is not reduced under this paragraph (j), and Amount 2 is $380 ($440 - $60). B's premium assistance amount for a coverage month is $350, the lesser of these two amounts.

(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)) (a stand-alone dental plan), the portion of the premium for the stand-alone 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*. The portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits is determined under guidance issued by the Secretary of Health and Human Services.

(3) *Example*. The following example illustrates the rules of this paragraph (k):

Example. (i) Taxpayer C and C's dependent, R, enroll in a qualified health plan. The premium for the plan in which C and R enroll is $7,200 ($600/month) (Amount 1). The plan does not provide dental coverage. C also enrolls in a stand-alone dental plan covering C and R. The portion of the premium for the dental plan allocable to pediatric dental benefits that are essential health benefits is $240 ($20 per month). The excess of the premium for C's applicable benchmark plan over C's contribution amount (the product of C's household income and the applicable percentage) is $7,260 ($605/month) (Amount 2).

(ii) Under this paragraph (k), the amount C pays for premiums (Amount 1) for purposes of computing the premium assistance amount is increased by the portion of the premium for the stand-alone dental plan allocable to pediatric dental benefits that are essential health benefits. Thus, the amount of the premiums for the plan in which C enrolls is treated as $620 for purposes of computing the amount of the premium tax credit. C's premium assistance amount for each coverage month is $605 (Amount 2), the lesser of Amount 1 (increased by the premiums allocable to pediatric dental benefits) and Amount 2.

(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*. The Commissioner may describe a comparable method in additional published guidance, see §601.601(d)(2) of this chapter.

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

(a) *Reconciliation*—(1) *Coordination of premium tax credit with advance credit payments*—(i) *In general*. A taxpayer must reconcile the amount of credit allowed under section 36B with advance credit payments on the 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.

(ii) *Responsibility for advance credit payments*. A taxpayer must reconcile all advance credit payments for coverage of any member of the taxpayer's family. If advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attests to the Exchange to the intention to claim a personal exemption deduction for the individual as part of the determination that the taxpayer is eligible for advance credit payments for coverage of the individual must reconcile the advance credit payments.

(iii) *Advance credit payment for a month in which an issuer does not provide coverage*. For purposes of reconciliation, a taxpayer does not have an advance credit payment for a month if the issuer of the qualified health plan in which the taxpayer or a family member is enrolled does not provide coverage for that month.

(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. The applicable benchmark plan for each coverage month is determined under §1.36B–3(f).

(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, 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 following examples illustrate the rules of this paragraph (a). In each example the taxpayer enrolls in a higher cost qualified health plan than the applicable benchmark plan:

Example 1. Household income increases. (i) Taxpayer A is single and has no dependents. The Exchange for A's rating area projects A's 2014 household income to be $27,925 (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 $2,952, computed as follows: benchmark plan premium of $5,200 less contribution amount of $2,248 (projected household income of $27,925 x .0805) = $2,952.

(ii) A's household income for 2014 is $33,622, 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 $2,006 (benchmark plan premium of $5,200 less contribution amount of $3,194 (household income of $33,622 x .095)). Because A's advance credit payments for 2014 are $2,952 and A's 2014 credit is $2,006, A has excess advance payments of $946. Under paragraph (a)(1) of this section, A's tax liability for 2014 is increased by $946. Because A's household income is between 300 percent and 400 percent of the Federal poverty line, if A's excess advance payments exceeded $1,250, under the limitation of paragraph (a)(3) of this section, A's additional tax liability would be limited to that amount.

Example 2. Household income increases, repayment limitation applies. The facts are the same as in *Example 1*, except that A's household income for 2014 is $43,560 (390 percent of the Federal poverty line for a family of one, applicable percentage 9.5). Consequently, A's premium tax credit for 2014 is $1,062 ($5,200 benchmark plan premium less contribution amount of $4,138 (household income of $43,560 x .095)). A's advance credit payments for 2014 are $2,952; therefore, A has excess advance payments of $1,890. Because A's household income is between 300 percent and 400 percent of the Federal poverty line, A's additional tax liability for the taxable year is $1,250 under the repayment limitation of paragraph (a)(3) of this section.

Example 3. *Household income decreases.* The facts are the same as in *Example 1*, except that A's actual household income for 2014 is $22,340 (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 $3,793 ($5,200 benchmark plan premium less contribution amount of $1,407 (household income of $22,340 x .063)). Because A's advance credit payments for 2014 are $2,952, A is allowed an additional credit of $841 ($3,793 less $2,952).

Example 4. Family size decreases. (i) Taxpayers B and C are married and have two children, K and L (ages 17 and 20), whom they claim as their dependents in 2013. The Exchange for their rating area projects their 2014 household income to be $63,388 (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's and C's ad-

vance credit payments for 2014 are $8,535, computed as follows: benchmark plan premium of $14,100 less contribution amount of $5,565 (projected household income of $63,388 x .0878) = $8,535.

(ii) In 2014, B and C do not claim L as their dependent. Consequently, B's and C's family size for 2014 is three, their household income of $63,388 is 332 percent of the Federal poverty line for a family of three (applicable percentage 9.5), and the annual premium for their applicable benchmark plan is $12,000. Their premium tax credit for 2014 is $5,978 ($12,000 benchmark plan premium less $6,022 contribution amount (household income of $63,388 x .095)). Because B's and C's advance credit payments for 2014 are $8,535 and their 2014 credit is $5,978, B and C have excess advance payments of $2,557. B's and C's additional tax liability for 2014 under paragraph (a)(1) of this section, however, is limited to $2,500 under paragraph (a)(3) of this section.

Example 5. Repayment limitation does not apply. (i) Taxpayer D is single and has no dependents. The Exchange for D's rating area approves advance credit payments for D based on 2014 household income of $39,095 (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 $1,486, computed as follows: benchmark plan premium of $5,200 less contribution amount of $3,714 (projected household income of $39,095 x .095) = $1,486.

(ii) D's actual household income for 2014 is $44,903, 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 $1,486 (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 $1,486.

Example 6. Coverage for less than a full taxable year. (i) Taxpayer F is single and has no dependents. In November 2013, the Exchange for F's rating area projects F's 2014 household income to be $27,925 (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 $246, computed as follows: benchmark plan premium of $5,200 less contribution amount of $2,248 (projected household income of $27,925 x .0805) = $2,952; $2,952/12 = $246.

(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 $28,707 (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 $2,832 (benchmark plan premium of $5,200 less contribution amount of $2,368 (household income of $28,707 x .0825)). Because F has only eight coverage months in 2014, F's credit is $1,888 ($2,832/12 x 8). Because F does not discontinue her Exchange coverage until November 1, 2014, F's advance credit payments for 2014 are $2,460 ($246 x 10). Consequently, F has excess advance payments of $572 ($2,460 less $1,888) and F's tax liability for 2014 is increased by $572 under paragraph (a)(1) of this section.

Example 7. 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 for E's rating area projects E's 2014 household income to be $30,260 (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 $275, computed as follows: benchmark plan premium of $5,200 less contribution amount of $1,906 (projected household income of $30,260 x .063) = $3,294; $3,294/12 = $275.

(ii) On August 1, 2014, E loses her eligibility for government-sponsored minimum essential coverage. E enrolls in the qualified health plan that covers 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 to be $675 as follows: benchmark plan premium of $10,000 less contribution amount of $1,906 (projected household income of $30,260 x .063) = $8,094; $8,094/12 = $675. E's household income for 2014 is $28,747 (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)	$1,925	($275 x 7)
Advance credit payments (Aug. to Dec.)	3,375	($675 x 5)
Total advance credit payments	5,300	
Benchmark plan premium (Jan. to July)	3,033	(($5,200/12) x 7)
Benchmark plan premium (Aug. to Dec.)	4,167	(($10,000/12) x 5)
Total benchmark plan premium	7,200	
Contribution amount (taxable year household income X applicable percentage)	1,679	($28,747 x .0584)
Credit (total benchmark plan premium less contribution amount)	5,521	

(iv) E's advance credit payments for 2014 are $5,300. E's premium tax credit is $5,521. Thus, E is allowed an additional credit of $221.

Example 8. Part-year coverage and changes in coverage months and applicable benchmark plan. (i) The facts are the same as in *Example 7*, except that F is 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. Thus, March through July are coverage months for F and August through December are coverage months for E and F.

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

Advance credit payments (March to July)	$1,375	($275 x 5)
Advance credit payments (Aug. to Dec.)	3,375	($675 x 5)
Total advance credit payments	4,750	
Benchmark plan premium (March to July)	2,167	(($5,200/12) x 5)
Benchmark plan premium (Aug. to Dec.)	4,167	(($10,000/12) x 5)
Total benchmark plan premium	6,334	
Contribution amount for 10 coverage months (taxable year household income X applicable percentage X 10/12)	1,399	($28,747 x .0584 x 10/12)
Credit (total benchmark plan premium less contribution amount)	4,935	

(iii) E's advance credit payments for 2014 are $4,750. E's premium tax credit is $4,935. Thus, E is allowed an additional credit of $185.

Example 9. Advance credit payments for months an issuer does not provide coverage. (i) Taxpayer F enrolls in a qualified health plan for 2014 and the Exchange approves advance credit payments. F pays the portion of the premium not covered by advance credit payments for January through April of 2014 but fails to make payments in May, June, and July. As a result, the issuer of the qualified health plan initiates the 3-month grace period under section 1412(c)(2)(B)(iv)(II) of the Affordable Care Act and 45 CFR 156.270(d). During the grace period the issuer continues to receive advance credit payments on behalf of F. On July 1 the issuer rescinds F's coverage retroactive to the end of the first month of the grace period, May 31.

(ii) Under paragraph (a)(1)(iii) of this section, F does not take into account advance credit payments for June or July of 2014 when reconciling the premium tax credit with advance credit payments under paragraph (a)(1) of this section.

(b) *Changes in filing status*—(1) *In general.* Except as provided in paragraph (b)(2) or (b)(3) of this section, 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 who marry during the taxable year*—(i) *In general.* Taxpayers who marry during and file a joint return for the taxable year may compute the additional tax imposed under paragraph (a)(1) of this section under paragraph (b)(2)(ii) of this section. Only taxpayers who are unmarried at the beginning of the taxable year and are married (within the meaning of section 7703) at the end of the taxable year, at least one of whom receives advance credit payments, may use this alternative computation.

(ii) *Alternative computation of additional tax liability*—(A) *In general.* The additional tax liability determined under this paragraph (b)(2)(ii) is equal to the excess of the taxpayers' advance credit payments for the taxable year over the amount of the alternative marriage-year credit. The alternative marriage-year credit is the sum of both taxpayers' alternative premium assistance amounts for the pre-marriage months and the premium assistance amounts for the marriage months. This paragraph (b)(2)(ii) may not be used to increase the additional premium tax credit computed under paragraph (a)(1)(i) of this section.

(B) *Alternative premium assistance amounts for pre-marriage months.* Taxpayers compute the alternative premium assistance amounts for each taxpayer for each full or partial month the taxpayers are unmarried as described in paragraph (a)(2) of this section, except that each taxpayer treats the amount of household income as one-half of the actual household income for the taxable year and treats family size as the number of individuals in the taxpayer's family prior to the marriage. The taxpayers may include a dependent of the taxpayers for the taxable year in either taxpayer's family size for the pre-marriage months.

(C) *Premium assistance amounts for marriage months.* Taxpayers compute the premium assistance amounts for each full month the taxpayers are married as described in paragraph (a)(2) of this section.

(3) *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 married 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.

(4) *Married taxpayers filing separate returns.* The premium tax credit is allowed to married (within the meaning of section 7703) taxpayers only if they file joint returns. See §1.36B–2(b)(2). A married taxpayer who receives advance credit payments and files an income tax return as married filing separately has received excess advance payments. Taxpayers who receive advance credit payments as married taxpayers and do not file a joint return must allocate the advance credit payments equally to each taxpayer. 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.

(5) *Taxpayers filing returns as head of household and married filing separately.* If taxpayers enroll in one qualified health plan and receive advance credit payments based on a filing status of married filing a

joint tax return, and one taxpayer properly files a tax return as head of household and the other taxpayer files a tax return as married filing separately for that taxable year, advance credit payments are allocated to each taxpayer equally for any period the taxpayers are enrolled in the same qualified health plan.

(6) *Examples*. The following examples illustrate the provisions of this paragraph (b). In each example the taxpayer enrolls in a higher cost qualified health plan than the applicable benchmark plan:

Example 1. Taxpayers marry during the taxable year, general rule for computing additional tax. (i) P is a single taxpayer with no dependents. In 2013 the Exchange for the rating area where P resides determines that P's 2014 household income will be $40,000 (358 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. P's monthly advance credit payment is $117, computed as follows: $5,200 benchmark plan premium minus contribution amount of $3,800 ($40,000 x .095) equals $1,400 (total advance credit payment); $1,400/12 = $117.

(ii) Q is a single taxpayer with two dependents. In 2013 the Exchange for the rating area where Q resides determines that Q's 2014 household income will be $35,000 (183 percent of the Federal poverty line, applicable percentage 5.52). Q enrolls in a qualified health plan. The premium for the applicable benchmark plan is $10,000. Q's monthly advance credit payment is $672, computed as follows: $10,000 benchmark plan premium minus contribution amount of $1,932 ($35,000 x .0552) equals $8,068 (total advance credit); $8,068/12 = $672.

(iii) P and Q marry on July 17, 2014 and enroll in a single policy for a qualified health plan covering four family members, effective August 1, 2014. The premium for the applicable benchmark plan is $14,000. Based on household income of $75,000 and a family size of four (325 percent of the Federal poverty line, applicable percentage 9.5), the Exchange approves advance credit payments of $573 per month, computed as follows: $14,000 benchmark plan premium minus contribution amount of $7,125 ($75,000 x .095) equals $6,875 (total advance credit); $6,875/12 = $573.

(iv) P and Q file a joint return for 2014 and report $75,000 in household income and a family size of four. P and Q compute their credit at reconciliation under paragraph (b)(1) of this section. They use the premiums for the applicable benchmark plans that apply for the months married and the months not married, and their contribution amount is 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 July)	$819
Advance payments for Q (Jan. to July)	4,704
Advance payments for P and Q (Aug. to Dec.)	2,865
Total advance payments	8,388
Benchmark plan premium for P (Jan. to July)	3,033
Benchmark plan premium for Q (Jan. to July)	5,833
Benchmark plan premium for P and Q (Aug. to Dec.)	5,833
Total benchmark plan premium	14,699
Contribution amount (taxable year household income X applicable percentage)	7,125
Credit (total benchmark plan premium less contribution amount)	7,574
Additional tax	814

(v) P's and Q's tax liability for 2014 is increased by $814 under paragraph (a)(1) of this section.

Example 2. Taxpayers marry during the taxable year, alternative computation of additional tax. (i) The facts are the same as in *Example 1*, except that P and Q compute their additional tax liability under paragraph (b)(2)(ii) of this section. P's and Q's additional tax is the excess of their advance credit payments for the taxable year ($8,388) over their alternative marriage-year credit, which is the sum of the alternative premium assistance amounts for the pre-marriage months and the premium assistance amounts for the marriage months.

(ii) P and Q compute the alternative marriage-year credit as follows:

Alternative premium assistance amounts for pre-marriage months	
Benchmark plan premium for P (Jan. to July)	$3,033 (($5,200/12) x 7)
Contribution amount (1/2 taxable year household income X applicable percentage) X 7/12)	$2,078 ($37,500 x .095 x 7/12)
Alternative premium assistance amount for P's pre-marriage months	$955 ($3,033 - $2,078)
Benchmark plan premium for Q (Jan. to July)	$5,833 (($10,000/12) x 7)
Contribution amount (1/2 taxable year household income X applicable percentage X 7/12)	$1,339 ($37,500 x .0612 x 7/12)
Alternative premium assistance amount for Q's pre-marriage months	$4,494 ($5,833 - $1,339)
Premium assistance amount for marriage months	
Benchmark plan premium for P and Q (Aug. to Dec.)	$5,833 (($14,000/12 x 5)
Contribution amount (taxable year household income X applicable percentage X 5/12)	$2,969 ($75,000 x .095 x 5/12)
Premium assistance amount for marriage months	$2,864 ($5,833 - $2,969)
Alternative marriage-year credit (sum of premium assistance amounts for pre-marriage months and marriage months): $955 + $4,494 + $2,864 = $8,313.	

(iii) P and Q reconcile their premium tax credit with advance credit payments by determining the excess of their advance credit payments ($8,388) over their alternative marriage-year credit ($8,313). P and Q must increase their tax liability by $75 under paragraph (a)(1) of this section.

Example 3. Taxpayers marry during the taxable year, alternative computation of additional tax, alternative marriage-year tax credit exceeds advance credit payments. The facts are the same as in *Example 2*, except that the amount of P's and Q's advance credit payments is $8,301. Thus, their alternative marriage-year credit ($8,313) exceeds the amount of their advance credit payments ($8,301). Under paragraph (b)(2)(ii)(A) of this section, the amount of additional tax liability and additional tax credit that P and Q report on their tax return is $0.

Example 4. Taxpayers marry during the taxable year, alternative computation of additional tax. (i) Taxpayer R is single and has no dependents. In 2013, the Exchange for the rating area where R resides determines that R's 2014 household income will be $40,000 (358 percent of the Federal poverty line, applicable percentage 9.5). R enrolls in a qualified health plan. The premium for the applicable benchmark plan is $5,200. R's monthly advance credit payment is $117, computed as follows: $5,200 benchmark plan premium minus contribution amount of $3,800 ($40,000 x .095) = $1,400 (total advance credit); $1,400/12 = $117.

(ii) Taxpayer S is single with no dependents. In 2013, the Exchange for the rating area where S resides determines that S's 2014 household income will be $20,000 (179 percent of the Federal poverty line, applicable percentage 5.33). S enrolls in a qualified health plan. The premium for the applicable benchmark plan is $5,200. S's monthly advance credit payment is $345, computed as follows: $5,200 benchmark plan premium minus contribution amount of $1,066 ($20,000 x .0533) = $4,134 (total advance credit); $4,134/12 = $345.

(iii) R and S marry in September 2014 and enroll in a single policy for a qualified health plan covering them both, beginning October 1, 2014. The premium for the applicable benchmark plan is $10,000. Based on household income of $60,000 and a family size of two (397 percent of the Federal poverty line, applicable percentage 9.5), R's and S's monthly advance credit payment is $358, computed as follows: $10,000 benchmark plan premium minus contribution amount of $5,700 ($60,000 x .095) = $4,300; $4,300/12 = $358. R's and S's advance credit payments for 2014 are $5,232, computed as follows:

Advance payments for R (Jan. to Sept.)	$1,053	($117 x 9)
Advance payments for S (Jan. to Sept.)	3,105	($345 x 9)
Advance payments for R and S (Oct. to Dec.)	1,074	($358 x 3)
Total advance payments	5,232	

(iv) R and S file a joint return for 2014 and report $62,000 in household income and a family size of two (410 percent of the FPL for a family of 2). Thus, under §1.36B–2(b)(2), R and S are not applicable taxpayers for 2014 and may not claim a premium tax credit for 2014. However, they compute their additional tax liability under paragraph (b)(2)(ii) of this section. R's and S's additional tax is the excess of their advance credit payments for the taxable year ($5,232) over their alternative marriage-year credit, which is the sum of the alternative premium assistance amounts for the pre-marriage months and the premium assistance amounts for the marriage months. In this case, R and S have no premium assistance amounts for the married months because their household income is over 400 percent of the Federal poverty line for a family of 2.

(v) R and S compute their alternative marriage-year credit as follows:

Premium assistance amount for pre-marriage months	
Benchmark plan premium for R (Jan. to Sept.)	$3,900 (($5,200/12) x 9)
Contribution amount ((1/2 taxable year household income X applicable percentage) x 9/12)	$2,053 ($31,000 x .0883 x 9/12)
Premium assistance amount for R's pre-marriage months	$1,847 ($3,900 - $2,053)
Benchmark plan premium for S (Jan. to Sept.)	$3,900 (($5,200/12) x 9)
Contribution amount ((1/2 taxable year household income X applicable percentage) x 9/12)	$2,053 ($31,000 x .0883 x 9/12)
Premium assistance amount for S's pre-marriage months	$1,847 ($3,900 - $2,053)
Premium assistance amount for marriage months	$0
Alternative marriage-year credit (sum of premium assistance amounts for pre-marriage months and marriage months): $1,847 + 1,847 + 0 = $3,694.	

(vi) R and S reconcile their premium tax credit with advance credit payments by determining the excess of their advance credit payments ($5,232) over their alternative marriage-year credit ($3,694). R and S must increase their tax liability by $1,538 under paragraph (a)(1) of this section.

Example 5. (i) *Taxpayers marry during the taxable year, no additional tax liability*. The facts are the same as in *Example 4*, except that S has no income and is enrolled in Medicaid for January through September 2014 and R's and S's household income for 2014 is $37,000 (245 percent of the Federal poverty line, applicable percentage 7.88). Their advance credit payments for 2014 are $2,707 ($1,053 for R for January to September and $1,654 for R and S for October to December). Their premium tax credit for 2014 is $3,484 (total benchmark premium of $6,400 less contribution amount of $2,916).

(ii) Because R's and S's premium tax credit of $3,484 exceeds their advance credit payments of $2,707, R and S are allowed an additional credit of $777. Although R and S marry in 2014, paragraph (b)(2) of this section (the alternative computation of additional tax for taxpayers who marry during the taxable year) does not apply because they do not owe additional tax for 2014.

Example 6. Taxpayers divorce during the taxable year, 50 percent allocation. (i) Taxpayers V and W are married and have two dependents. In 2013, the Exchange for the rating area where the family resides determines that their 2014 household income will be $76,000 (330 percent of the Federal poverty line for a family of 4, applicable percentage 9.5). V and W 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 V and W's contribution amount of $7,220 ($76,000 x .095) equals $6,880 (total advance credit); $6,880/12 = $573.

(ii) V and W divorce on June 17, 2014, and obtain separate qualified health plans beginning July 1, 2014. V enrolls based on household income of $60,000 and a family size of three (314 percent of the Federal poverty line, applicable percentage 9.5). The premium for the applicable benchmark plan is $10,000. The Exchange approves advance credit payments of $358 per month, computed as follows: $10,000 benchmark plan premium minus V's contribution amount of $5,700 ($60,000 x .095) equals $4,300 (total advance credit); $4,300/12 = $358.

(iii) W enrolls based on household income of $16,420 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 $381 per month, computed as follows: $5,200 benchmark plan premium minus W's contribution amount of $627 ($16,420 x .0382) equals $4,573 (total advance credit); $4,573/12 = $381. V and W 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) V and W each compute their credit at reconciliation under paragraph (b)(1) of this section, using the premiums for the applicable benchmark plans that apply to them for the months married and the months not married, and the contribution amount based on their Federal poverty line percentages at the end of the taxable year. Under paragraph (b)(3) of this section, because V and W do not agree on an allocation, V and W must equally allocate the benchmark plan premium ($7,050) and the advance credit payments ($3,438) for the six-month period January through June 2014 when they are married and enrolled in the same qualified health plan. Thus, V and W each are allocated $3,525 of the benchmark plan premium ($7,050/2) and $1,719 of the advance credit payments ($3,438/2) for January through June.

(v) V reports on his 2014 tax return $60,000 in household income and family size of three. W reports on her 2014 tax return $16,420 in household income and family size of one. V and W reconcile their premium tax credit with advance credit payments as follows:

	V	W
Allocated advance payments (Jan. to June)	$ 1,719	$ 1,719
Actual advance payments (July to Dec.)	2,148	2,286
Total advance payments	3,867	4,005
Allocated benchmark plan premium (Jan. to June)	3,525	3,525
Actual benchmark plan premium (July to Dec.)	5,000	2,600
Total benchmark plan premium	8,525	6,125
Contribution amount (taxable year household income X applicable percentage)	5,700	627
Credit (total benchmark plan premium less contribution amount)	2,825	5,498
Additional credit		1,493
Additional tax	1,042	

(vi) Under paragraph (a)(1) of this section, on their tax returns V's tax liability is increased by $1,042 and W is allowed $1,493 as additional credit.

Example 7. Taxpayers divorce during the taxable year, allocation in proportion to household income. (i) The facts are the same as in *Example 6*, except that V and W decide to allocate the benchmark plan premium ($7,050) and the advance credit payments ($3,438) for January through June 2014 in proportion to their household incomes (79 percent and 21 percent). Thus, V is allocated $5,570 of the benchmark plan premiums ($7,050 x .79) and $2,716 of the advance credit payments ($3,438 x .79), and W is allocated $1,481 of the benchmark plan premiums ($7,050 x .21) and $722 of the advance credit payments ($3,438 x .21). V and W reconcile their premium tax credit with advance credit payments as follows:

	V	W
Allocated advance payments (Jan. to June)	$2,716	$ 722
Actual advance payments (July to Dec.)	2,148	2,286
Total advance payments	4,864	3,008
Allocated benchmark plan premium (Jan. to June)	5,570	1,481
Actual benchmark plan premium (July to Dec.)	5,000	2,600
Total benchmark plan premium	10,570	4,081
Contribution amount (taxable year household income X applicable percentage)	5,700	627
Credit (total benchmark plan premium less contribution amount)	4,870	3,454
Additional credit	6	446

(ii) Under paragraph (a)(1) of this section, on their tax returns V is allowed an additional credit of $6 and W is allowed an additional credit of $446.

Example 8. Married taxpayers filing separate tax returns. (i) Taxpayers X and Y are married and have two dependents. In 2013, the Exchange for the rating area where the family resides determines that their 2014 household income will be $76,000 (330 percent of the Federal poverty line for a family of 4, applicable percentage 9.5). W and Y enroll in a qualified health plan for 2014. The premium for the applicable benchmark plan is $14,100. X's and Y's monthly advance credit payment is $573, computed as follows: $14,100 benchmark plan premium minus X's and Y's contribution amount of $7,220 ($76,000 x .095) equals $6,880 (total advance credit); $6,880/12 = $573.

(ii) X and Y file income tax returns for 2014 using a married filing separately filing status. X reports household income of $60,000 and a family size of three (314 percent of the Federal poverty line). Y reports household income of $16,420 and a family size of one (147 percent of the Federal poverty line).

(iii) Because X and Y are married but do not file a joint return for 2014, X and Y are not applicable taxpayers and are not allowed a premium tax credit for 2014. See §1.36B–2(b)(2). Under paragraph (b)(4) of this section, half of the advance credit payments ($6,880/2 = $3,440) is allocated to X and half is allocated to Y for purposes of determining their excess advance payments. The repayment limitation described in paragraph (a)(3) of this section applies to X and Y based on the household income and family size reported on each return. Consequently, X's tax liability for 2014 is increased by $2,500 and Y's tax liability for 2014 is increased by $600.

Example 9. (i) The facts are the same as in *Example 8*, except that X and Y live apart for over 6 months of the year and X properly files an income tax return as head of household. Under section 7703(b), X is treated as unmarried and therefore is not required to file a joint return. If X otherwise qualifies as an applicable taxpayer, X may claim the premium tax credit based on the household income and family size X reports on the return. Y is not an applicable taxpayer and is not eligible to claim the premium tax credit.

(ii) X must reconcile the amount of credit with advance credit payments under paragraph (a) of this section. The premium for the applicable benchmark plan covering X and his two dependents is $9,800. X's premium tax credit is computed as follows: $9,800 benchmark plan premium minus X's contribution amount of $5,700 ($60,000 x .095) equals $4,100.

(iii) Under paragraph (b)(5) of this section, half of the advance payments ($6,880/2 = $3,440) is allocated to X and half is allocated to Y. Thus, X is entitled to $660 additional premium tax credit ($4,100 - $3,440). Y has $3,440 excess advance payments,

which is limited to $600 under paragraph (a)(3) of this section.

§1.36B–5 Information reporting by Exchanges.

(a) *Information required to be reported.* An Exchange must report to the Internal Revenue Service and each taxpayer the following information for the qualified health plan or plans in which the taxpayer or a member of the taxpayer's family enrolls through the Exchange—

(1) The premium 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 in which the taxpayer or family member enrolls without reduction for advance credit payments;

(3) The aggregate amount of any advance credit payments;

(4) The name, address and Social Security number (SSN) of the primary insured and the name and SSN or adoption taxpayer identification number 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) Any other information required in published guidance, see §601.601(d)(2) of this chapter, necessary to determine whether a taxpayer has received excess advance payments.

(b) *Time of reporting.* [Reserved]

(c) *Manner of reporting.* The Commissioner may provide rules in published guidance, see §601.601(d)(2) of this chapter, for the 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).

* * * * *

PART 602 — OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 5. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 6. In §602.101, paragraph (b) is amended by adding an entry in numerical order to the table to read as follows:

§602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB Control No.
* * * * *	
1.36B–5	1545–2232
* * * * *	

Steven T. Miller,
Deputy Commissioner for Services and Enforcement.

Approved May 16, 2012.

Emily S. McMahon,
Acting Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on May 18, 2012, 11:15 a.m., and published in the issue of the Federal Register for May 23, 2012, 77 F.R. 30377)

Section 108.—Income from Discharge of Indebtedness

26 CFR 108(a)–1: Income from discharge of indebtedness.
(Also: Sections 61(a)(12); 704; 752; 1.752–3).

Income from discharge of indebtedness. This ruling amplifies Revenue Ruling 92–53, 1992–2 C.B. 48, by describing how discharged partnership excess nonrecourse debt is taken into account in measuring the insolvency of the partners under section 108(d)(3) of the Code. The ruling provides that to the extent discharged excess nonrecourse debt generates cancellation of indebtedness (COD) income that is allocated under section 704(b) (and the regulations thereunder), each partner treats its portion of the discharged excess nonrecourse debt related to such COD income as a liability in measuring insolvency under section 108(d)(3). Rev. Rul. 92–53 amplified.

Rev. Rul. 2012–14

ISSUE

How do partners treat the partnership's discharged excess nonrecourse debt in measuring insolvency under § 108(d)(3) of the Internal Revenue Code?

FACTS

X, an investor other than a partnership, and Holdco, a corporation, are equal partners in PRS, a partnership for federal tax purposes. In Year 1, PRS borrows

$1,000,000 from Bank and signs a note payable to Bank for $1,000,000 that bears interest at a fixed market rate payable annually. The note is secured by real estate valued in excess of $1,000,000 that PRS acquires from Seller, in part with the proceeds of the note. The note is a nonrecourse liability within the meaning of § 1.752–1(a)(2) of the Income Tax Regulations. Neither PRS nor its partners (X and Holdco) are personally liable on the note.

In Year 2, when the value of the real estate is $800,000 and the outstanding principal on the note is $1,000,000, Bank agrees to modify the terms of the note by reducing the note's principal amount to $825,000. At the time that the Bank reduces the note's principal amount, PRS has no partnership minimum gain with respect to the note under § 1.704–2(d)(1). The modified note bears adequate stated interest within the meaning of § 1274(c)(2). The PRS partnership agreement provides for income to be allocated equally to X and Holdco under § 704(b) and the regulations thereunder. X and Holdco share PRS nonrecourse liabilities equally under § 1.752–3. At the time of the modification of the note, X and Holdco have no assets or liabilities other than their partnership interests in PRS. PRS's sole asset is the real estate subject to the note, and PRS's sole liability is the note. The specific exclusion provided by § 108(a)(1)(A) (bankruptcy exception) does not apply in this case.

LAW

Section 61(a)(12) provides that gross income includes income from the discharge of indebtedness (COD). Section 1.61–12(a) provides that the discharge of indebtedness, in whole or in part, may result in the realization of income.

Section 108(a)(1)(B) generally excludes discharged indebtedness from a taxpayer's gross income if the discharge occurs when the taxpayer is insolvent. Section 108(a)(3) limits the amount of income excluded by reason of § 108(a)(1)(B) to the amount by which the taxpayer is insolvent.

Section 108(d)(3) defines "insolvent" as the excess of liabilities over the fair market value of assets. That section further provides that whether a taxpayer is insolvent, and the amount by which the taxpayer is insolvent, is determined on the basis of the taxpayer's assets and liabilities immediately before the discharge.

Section 108(d)(1) provides that indebtedness of the taxpayer means any indebtedness for which the taxpayer is liable, or subject to which the taxpayer holds property. Section 108(d)(6) provides that in the case of cancelled partnership debt, the insolvency exception of § 108(a)(1)(B) applies at the partner level.

Rev. Rul. 92–53, 1992–2 C.B. 48, provides that the amount by which a nonrecourse debt exceeds the fair market value of the property securing the debt (excess nonrecourse debt) is treated as a liability in determining insolvency for purposes of § 108 to the extent that the excess nonrecourse debt is discharged.

ANALYSIS

In order to properly apply Rev. Rul. 92–53 in a partnership context, the partnership's discharged excess nonrecourse debt should be associated with the partner who in the absence of the insolvency or other § 108 exclusion would be required to pay the tax liability arising from the discharge of that debt. Therefore, a partnership's discharged excess nonrecourse debt is treated as a liability of the partners for purposes of measuring the partners' insolvency under § 108(d)(3) based upon how the COD income with respect to that portion of the debt is allocated among the partners under § 704(b) and the regulations thereunder. See Rev. Rul. 99–43, 1999–2 C.B. 506, and Rev. Rul. 92–97, 1992–2 C.B. 124, regarding the application of § 704(b) to allocations of COD income.

In this case, Bank cancels $175,000 of PRS's $200,000 excess nonrecourse debt, generating $175,000 of COD income. PRS's $175,000 COD income is allocated equally between X and Holdco under § 704(b) and the regulations thereunder. For purposes of measuring the insolvency of the partners, PRS's discharged excess nonrecourse debt is treated as a liability of its partners based upon the COD income allocation. Thus, X treats $87,500 of PRS's debt as a liability of X, and Holdco treats $87,500 of PRS's debt as a liability of Holdco. X and Holdco treat their shares of the cancelled PRS excess nonrecourse debt as their own liabilities in determining whether, and to what extent, each is insolvent within the meaning of § 108(d)(3).

X and Holdco have no assets or liabilities other than their partnership interests in PRS. In this case, the value of X's and Holdco's partnership interests in PRS is zero.

Immediately before Bank discharges the indebtedness, X's liability exceeds the value of X's partnership interest by $87,500, and similarly Holdco's liability exceeds the value of Holdco's partnership interest by $87,500. Therefore, X and Holdco are each insolvent to the extent of $87,500 under § 108(d)(3). Accordingly, X and Holdco each exclude their $87,500 amount of COD income under § 108(a)(1)(B).

HOLDING

For purposes of measuring a partner's insolvency under § 108(d)(3), each partner treats as a liability an amount of the partnership's discharged excess nonrecourse debt that is based upon the allocation of COD income to such partner under § 704(b) and the regulations thereunder.

EFFECT ON OTHER REVENUE RULINGS

Rev. Rul. 92–53 is amplified.

DRAFTING INFORMATION

The principal authors of this ruling are Kevin I. Babitz and Anne W. Bryson of the Office of Associate Chief Counsel (Passthroughs & Special Industries). For further information regarding this revenue ruling, contact Kevin I. Babitz, Anne W. Bryson, or Charlotte Chyr at (202) 622–3060 (not a toll-free call).

Part III. Administrative, Procedural, and Miscellaneous

Extension of Interim Guidance on Modification of Section 833 Treatment of Certain Health Organizations

Notice 2012–37

PURPOSE

This notice extends the interim guidance provided in Notice 2011–51, 2011–27 I.R.B. 36, and Notice 2010–79, 2010–49 I.R.B. 809, as clarified and modified by Notice 2011–4, 2011–2 I.R.B. 282, and Rev. Proc. 2011–14, 2011–4 I.R.B. 330, on the interpretation and application of § 833(c)(5) of the Internal Revenue Code (Code).

BACKGROUND

Section 9016 of the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010) (Affordable Care Act), added § 833(c)(5) to the Code, effective for taxable years beginning after December 31, 2009. Section 833(c)(5) provides that § 833 does not apply to an otherwise-eligible organization unless the organization's medical loss ratio (MLR) during the taxable year is not less than 85 percent. For purposes of section 833(c)(5), an organization's MLR is equal to the "percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act)."

In December 2010, the Department of Health and Human Services (HHS) issued interim final regulations implementing § 2718 of the Public Health Service Act (PHSA), 75 Fed. Reg. 74864 (December 1, 2010). The Department of Treasury (Treasury) and the Internal Revenue Service (the Service) subsequently issued Notice 2010–79 providing interim guidance and transitional relief on (1) the computation of a taxpayer's MLR for purposes of § 833(c)(5), (2) the consequences of nonapplication of § 833 if § 833(c)(5) is not satisfied, and (3) changes in accounting method by reason of application or nonapplication of § 833. The interim guidance applied to the first taxable year beginning after December 31, 2009. In Notice 2011–51, Treasury and the Service extended the interim guidance and transitional relief to the first taxable year beginning after December 31, 2010.

In December 2011, HHS issued final regulations, codified at 45 C.F.R. pt. 158, implementing the reporting requirements under § 2718 of the PHSA, 76 Fed. Reg. 76574 (December 7, 2011). The final regulations became effective January 3, 2012, and the first reporting under § 2718 of the PHSA is due in June 2012.

EXTENSION OF INTERIM GUIDANCE

Section 833(c)(5) looks to information reported under § 2718 of the PHSA for purposes of determining whether a taxpayer's MLR is at least 85 percent. Now that HHS has issued final regulations under § 2718, Treasury and the Service expect to propose regulations under § 833(c)(5). However, Treasury and the Service believe that the development of those proposed regulations should reflect the experience of both HHS and the affected taxpayers with the implementation of the HHS § 2718 regulations, the first reporting under which occurs this year. Moreover, once Treasury and the Service have published proposed regulations, affected taxpayers will need time to determine the potential effect of the proposed regulations, to provide comments thereon, and to consider whether any program adjustments may be necessary in advance of the effective date of final regulations. Accordingly, the interim guidance and transitional relief provided in Notices 2010–79 and 2011–51 are extended through the first taxable year beginning after December 31, 2012.

REQUEST FOR COMMENTS

Treasury and the Service invite comments on all aspects of § 833(c)(5), including how the proposed regulations they anticipate issuing under that provision might take account of the specific reporting required under § 2718 of the PHSA and coordinate the MLR computations under § 2718 of the PHSA and § 833(c)(5).

Comments should be submitted in writing on or before September 10, 2012. Comments should include a reference to Notice 2012–37. Send submissions to CC:PA:LPD:PR (Notice 2012–37), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20224. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2012–37), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20004, or sent electronically, via the following e-mail address: *Notice.comments@irscounsel.treas.gov*. Please include "Notice 2012–37" in the subject line of any electronic communications. All comments submitted will be available for public inspection and copying.

EFFECT ON OTHER DOCUMENTS

Notice 2011–51 is modified and superseded.

CONTACT INFORMATION

The principal author of this notice is Graham R. Green of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this notice, contact Graham R. Green at (202) 622–3970 (not a toll-free call).

Implementation of Rev. Rul. 2006–57—Issues for Public Comment

Notice 2012–38

PURPOSE

This notice requests public comments on issues associated with Revenue Ruling 2006–57, 2006–2 C.B. 911, which became effective on January 1, 2012. Rev. Rul. 2006–57 provides guidance on the use of smartcards, debit or credit cards, or other electronic media to provide qualified transportation fringes under sections 132(a)(5) and (f) of the Internal Revenue Code (the Code). The Treasury Department and the Internal Revenue Service have become aware of changes in technology that may give rise to the need for

additional guidance on the use of electronic media to provide transit benefits.

BACKGROUND

Section 132(a)(5) of the Code provides that any fringe benefit that is a qualified transportation fringe is excluded from gross income. Section 132(f)(1) provides that the term "qualified transportation fringe" means, when provided by an employer to an employee, (1) transportation in a commuter highway vehicle between home and work, (2) any transit pass, (3) qualified parking, or (4) any qualified bicycle commuting reimbursement.

Section 132(f)(5)(A) provides that a transit pass is any pass, token, farecard, voucher or similar item entitling a person to transportation (or transportation at a reduced price) if such transportation is on mass transit facilities or is provided by any person in the business of transporting persons for compensation or hire in a commuter highway vehicle.

Section 132(f)(3) of the Code generally allows employers to use cash reimbursement arrangements to provide employees with qualified transportation fringe benefits. This section, however, prohibits use of such arrangements to provide transit benefits "if a voucher or similar item which may be exchanged only for a transit pass" is "readily available." Section 1.132–9, Q/A–16(b) of the Regulations specifies that a voucher or similar item is not readily available if the entity providing it imposes restrictions that effectively prevent the employer from obtaining vouchers appropriate for distribution to employees. Examples of such restrictions include:

1. Excessive fare media charges: The term "fare media charges" refers to extra fees that the voucher-provider requires employers to incur to furnish employees with vouchers. Such fees are excessive if the average annual fare media charges that the employer incurs to provide its employees with transit benefits via vouchers are more than one percent of the average annual value of the vouchers for a transit system.
2. Advance purchase requirements: A voucher-provider imposes an excessive advance purchase requirement if it "does not offer vouchers at regular intervals or fails to provide the voucher within a reasonable period after receiving payment for the voucher." The regulations clarify that a requirement that employers purchase vouchers only once per year is an excessive advance purchase requirement, but a requirement that an employer purchase vouchers on a monthly basis is not.
3. Purchase quantity requirements: A voucher is not readily available if the voucher-provider requires the employer to purchase vouchers in quantities that are not reasonably appropriate considering the number of employees who use mass transit.
4. Limitations on denominations of available vouchers: A voucher is not readily available if the voucher-provider requires the employer to purchase vouchers in denominations that are not appropriate for distribution to the employer's employees.

Section 1.132–9, Q/A–16 of the Regulations provides that a qualified transportation fringe includes cash reimbursement for transit passes made under a *bona fide* reimbursement arrangement that meets substantiation requirements specified in the regulations. In discussing the application of Section 132(f) of the Code to reimbursements, Section 1.132–9, Q/A–16(a) of the Regulations provides that a payment made before the date an expense has been incurred or paid is not a reimbursement; nor does a *bona fide* reimbursement arrangement include an arrangement that is dependent solely upon an employee certifying in advance that the employee will incur expenses at some future date. Employers must implement reasonable procedures to ensure that employees have incurred expenses for transit passes in an amount equal to the reimbursement. What constitutes a reasonable procedure depends on the facts and circumstances of a particular arrangement. The Regulations further require employees to provide any such substantiation within a "reasonable period of time."

Rev. Rul. 2006–57 provides guidance on the use of smartcards, debit or credit cards, or other electronic media to provide employees with transportation fringes. The ruling was originally scheduled to become effective January 1, 2008. However, Treasury and the IRS delayed the effective date of the ruling several times in order to give transit systems additional time to modify their technology to comply with the requirements set forth in Revenue Ruling 2006–57, most recently in Notice 2010–94, 2010–52 I.R.B. 927, which delayed the effective date until January 1, 2012. There have been no subsequent notices delaying the effective date of the revenue ruling. The revenue ruling is therefore now effective.

The revenue ruling includes four situations that illustrate the tax treatment of arrangements under which employers use electronic media to provide employees with transportation benefits.

Employers in the first situation distribute "smartcards" to their employees. Employees use the fare media value that is stored on these cards to pay for transportation on the local transit system. The fare media value stored on the cards is useable only to pay for transportation on the local transit system. The revenue ruling therefore concludes that the smartcards qualify as transit system vouchers under section 1.132–9(b) of the Regulations. The value of the fare media stored on the smartcards, up to the applicable monthly limit, is excludable from an employee's gross income as a qualified transportation benefit. Under section 1.132–9(b) Q/A–18, employees are not required to substantiate their use of the smartcards.

In the second situation, employers furnish employees with debit cards. These debit cards are restricted for use only at merchant terminals at points of sale at which only fare media for the local transit system is sold. Employers make monthly payments to the debit card provider, which the debit card provider then allocates to each employee's card. The revenue ruling concludes that these terminal-restricted debit cards qualify as transit system vouchers under section 1.132–9(b) because, similar to the smartcards in the first situation, they can be used only to purchase fare media on the local transit system. Amounts stored on these debit cards are excludable from employee's gross incomes to the extent that they do not exceed the applicable monthly limit and employees are not required to substantiate their use of the debit cards.

The revenue ruling's third situation depicts an arrangement under which employers provide employees with debit cards that employees can use to purchase transit benefits under circumstances in which vouchers or similar items exchangeable only for transit passes are not readily available. These debit cards are restricted for use only at merchants that have been assigned a merchant category code (MCC-restricted) indicating that the merchants sell fare media for the local transit system. The merchants may or may not sell other merchandise. The revenue ruling concludes that these debit cards do not qualify as transit system vouchers under section 1.132–9(b) because there is nothing in the debit card technology that prevents the use of the cards to purchase items other than fare media for the local transit system. However, because transit passes are not readily available to the employers in these circumstances, the employers are permitted to distribute transit benefits via *bona fide* cash reimbursement arrangements. The revenue ruling concludes that the facts of this third situation result in a *bona fide* cash reimbursement arrangement because employees are required to pay for fare media with after-tax amounts during their first month of participation in the transportation benefit program, the employees must substantiate the amount of their monthly expenses to the employers, and the employers provide funds that the debit card provider allocates to each debit card in an amount that does not exceed the lesser of the applicable monthly limit or the amount of the employee's substantiated fare media expenses for the prior month.

The facts in the fourth situation are the same as those in the third situation, except that the employer provides employees with the MCC-restricted debit cards before they begin work. Before using the MCC-restricted debit cards, employees must certify that the card will be used only to purchase transit passes. Further, written on each card is a statement that the card is to be used only for transit passes and, by using the card, the employees certify that the card is being used only to purchase transit passes. The revenue ruling concludes that the arrangement in the fourth situation does not meet the requirements of a *bona fide* cash reimbursement arrangement because it provides for advances rather than reimbursements and because it relies solely on employee certifications provided before expenses are incurred. Those certifications, standing alone, do not provide the substantiation of expenses incurred necessary for there to be a *bona fide* reimbursement arrangement.

At the time Rev. Rul. 2006–57 was issued, the Treasury Department and the Internal Revenue Service (IRS) lacked sufficient factual context to develop guidance regarding whether terminal-restricted debit cards were "readily available". The revenue ruling indicates that the IRS intends "to issue guidance clarifying under what situations the cards are considered to be readily available and thus preclude cash reimbursement for transit benefits." In the interim, employers may use *bona fide* cash reimbursement arrangements when the only available voucher or similar item is a terminal-restricted debit card.

REQUESTS FOR COMMENT

Treasury and the IRS have become aware that changes in fare media and in transit benefit administration may have created the need for guidance in addition to the guidance issued concerning the specific situations described in Rev. Rul. 2006–57. Developments in technology, an increase in the number of transit systems and third parties providing electronic media for transit use, and the trend away from use of paper fare media provide a basis for concluding that the four situations described in Rev. Rul. 2006–57 may not cover the full range of available electronic media for providing fare media.

Treasury and the IRS request comments on how electronic media may meet the statutory requirements under section 132(f) for providing transit benefits, either as vouchers or transit passes or through *bona fide* cash reimbursement arrangements in a manner other than those described in situations one through four in Rev. Rul. 2006–57. Also, Treasury and the IRS request comments on the availability of terminal-restricted cards and any other electronic media qualifying as vouchers or transit passes for purposes of determining whether such items are readily available and, therefore, cash reimbursement arrangements for providing transit benefits should be prohibited. Finally, Treasury and the IRS request comments on challenges employers encounter in transitioning from paper transit passes or vouchers to electronic media that qualify as vouchers or transit passes, or from cash reimbursement arrangements to electronic media qualifying as transit passes or vouchers.

1. Electronic Media other than those described in Revenue Ruling 2006–57

Revenue Ruling 2006–57 distinguishes the tax-treatment of terminal-restricted debit cards and MCC-restricted debit cards under the facts described in the situations. Specifically, the revenue ruling concludes that under the facts described in those situations. a terminal-restricted debit card qualifies as a transit pass under section 132(f) of the Code, while MCC-restricted debit cards do not qualify as transit passes because the holders may be able use the MCC-restricted debit cards to purchase items other than fare media. Treasury and the IRS have become aware of technological advances that may enable providers of MCC-restricted debit cards to limit the use of these cards to such an extent that it is almost, if not entirely, impossible to use the cards to purchase any items other than fare media. In light of these technological advances, Treasury and the IRS request comments on circumstances in which the use of MCC-restricted debit cards is sufficiently circumscribed so that the cards qualify as transit passes or vouchers providing transit benefits.

2. Definition of "readily available"

As discussed in the Background section, employers may use *bona fide* cash reimbursement arrangements to provide employees with qualified transportation fringe benefits only if vouchers or similar items are not readily available. The regulations state that a voucher or similar item is not readily available if the entity providing the item imposes restrictions that effectively prevent employers from obtaining vouchers appropriate for distribution to employees. Revenue Ruling 2006–57 did not provide guidance on what constitutes "readily available" in the context of terminal-restricted debit cards, but the revenue ruling indicated that this issue will be addressed in future guidance. The IRS requests comments on whether terminal-restricted debit cards are widely

used, the availability of terminal-restricted debit cards in areas where paper vouchers are no longer accepted by the local transit system, the ease with which employers can acquire terminal-restricted debit cards to distribute transit benefits, and any issues that employers and/or employees are encountering in connection with the use of such cards.

3. Transitions from paper transit system vouchers to electronic vouchers or to *bona fide* cash reimbursement systems.

Treasury and the IRS have become aware of issues arising in locations in which transit systems no longer accept paper transit passes. Some benefit providers in these locations that previously provided transit benefits via paper vouchers now plan to provide benefits via electronic media that qualify as transit passes or vouchers, or via *bona fide* cash reimbursement arrangements because no other transit passes or vouchers are readily available for use on the transit systems. The IRS requests administrators of, and participants in, such arrangements to provide comments concerning any issues that have arisen related to the transition from paper vouchers to other methodologies for providing transportation fringe benefits. For example, employers transitioning from paper transit passes to cash reimbursement arrangements may have questions regarding how to comply with the requirement in section 1.132–9, Q/A–16 that employees incur expenses prior to the date employers make payments as they move from an in-kind arrangement, which does not have such a requirement regarding the timing of expenses, to a cash reimbursement arrangement.

4. Application of *bona fide* reimbursement arrangement requirements in context of electronic media.

Treasury and the IRS also requests comments concerning the circumstances under which the provision of transit benefits via electronic media constitutes a *bona fide* reimbursement arrangement. For example, the IRS has become aware of arrangements under which employers load funds onto electronic media at the beginning of each month after receiving an employee certification of expected transit expenses and then utilize one or both of the following: (1) true-up mechanisms under which employers periodically review statements detailing employees' transactions and require employees to repay the costs of any "unauthorized" transactions, or (2) sweep-away mechanisms under which employers delete any unused amounts from employees' electronic media at the end of each month. The IRS requests comments concerning whether arrangements under which employers credit employees' electronic media with amounts before the employees actually incur transit expenses may qualify as *bona fide* cash reimbursement arrangements through use of one or both of these safeguards and if the employee provides reasonable substantiation of the expenses incurred within the meaning of Section 1.132–9, Q/A–16(c). The IRS also requests comments concerning any other similar safeguards that should enable such up-front crediting of employees' electronic media to qualify as *bona fide* cash reimbursement arrangements.

REQUEST FOR COMMENTS

The IRS requests comments on the issues described above. Comments should be submitted in writing on or before August 27, 2012. All Comments will be available for public inspection and copying. Comments may be submitted in one of three ways:

1. By mail to CC:PA:LPD:PR (Notice 2012–38), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.

2. Electronically to *Notice.Comments@irscounsel.treas.gov*. Please include "Notice 2012–38" in the subject line of any electronic communications.

3. By hand-delivery Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2012–38), Courier's Desk, Internal Revenue Service, 1111 Constitution Ave., NW, Washington, DC 20224.

DRAFTING INFORMATION

The principal author of this announcement is Syd Gernstein of the Employment Tax 2, Tax Exempt and Government Entities Division. For further information regarding this announcement, contact Syd Gernstein or Jean Casey at (202) 622–6040 (not a toll-free call).

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D. —Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
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[1] A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2011–27 through 2011–52 is in Internal Revenue Bulletin 2011–52, dated December 27, 2011.

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