

Distributing may claim the benefit of the transition rule of paragraph (i)(2) of this section only if all steps relevant to the determination of Predecessor of Distributing status are described in the binding agreement, ruling request, announcement, or filing described in paragraph (i)(2)(i) of this section.

(3) *Exception.* Notwithstanding paragraph (i)(1) or (2) of this section, Distributing and any affiliated group that it is a member of as of the beginning of the date on which a distribution (as defined in paragraph (i)(2)(ii) of this section) may apply this section in its entirety to that distribution if it occurs after November 22, 2004. However, under this paragraph (i)(3), taxpayers must consistently apply this section in its entirety to all distributions occurring after November 22, 2004, that are part of the same Plan.

(j) *Expiration date.* The applicability of this section expires on or before December 16, 2019.

John Dalrymple,

Deputy Commissioner for Services and Enforcement.

Approved: December 1, 2016.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 301

[TD 9804]

RIN 1545–BN50

Premium Tax Credit Regulation VI

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final Regulations.

SUMMARY: This document contains final regulations relating to the health insurance premium tax credit (premium tax credit). These final regulations affect individuals who enroll in qualified health plans through Health Insurance Exchanges (Exchanges, also called Marketplaces) and claim the premium tax credit, and Exchanges that make qualified health plans available to individuals and employers. These final regulations also affect individuals who are eligible for employer-sponsored health coverage.

DATES: *Effective Date:* These regulations are effective December 19, 2016.

Applicability Date: For dates of applicability, see §§ 1.36B–1(o), 1.36B–2(e), 1.36B–3(n), 1.36B–5(h), and 1.6011–8(b).

FOR FURTHER INFORMATION CONTACT:

Steve Toomey at (202) 317–4735, Shareen Pflanz at (202) 317–4727, or Lisa Mojiri-Azad at (202) 317–4649 (not toll-free calls).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these final regulations has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545–2232.

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

The burden for the collection of information contained in these regulations will be reflected in the burden estimate for Form 1095–A, *Health Insurance Marketplace Statement*, which is the form that the Marketplace will use to submit the information described in the final regulations.

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

Background

This document contains final regulations amending the Income Tax Regulations (26 CFR part 1) under section 36B relating to the health insurance 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). Final regulations under section 36B (TD 9590) were published on May 23, 2012 (77 FR 30,385). These regulations were amended in 2014 by TD 9663, published on May 7, 2014 (79 FR 26,117), and in 2015 by TD 9745, published December 18, 2015 (80 FR

78,974). On July 8, 2016, a notice of proposed rulemaking (REG–109086–15) was published in the **Federal Register** (81 FR 44,557). Written comments responding to the proposed regulations were received. The comments have been considered in connection with these final regulations and are available for public inspection at www.regulations.gov or on request. No public hearing was requested or held. After consideration of all the comments, the proposed regulations are adopted, in part, as amended by this Treasury decision. The rules proposed under REG–109086–15 on the effect of opt-out arrangements on an employee's required contribution for employer-sponsored coverage have been reserved and the Treasury Department and the IRS expect to finalize those regulations separately (see, section 1.d of this preamble).

Summary of Comments and Explanation of Provisions

1. Eligibility

a. Applicable Taxpayers

A taxpayer is eligible for a premium tax credit only if the taxpayer is an applicable taxpayer. To be an applicable taxpayer, a taxpayer's household income generally must be between 100 percent and 400 percent of the Federal poverty line (FPL) for the taxpayer's family size. The existing regulations in § 1.36B–2(b)(6) allow a taxpayer whose household income is below 100 percent of the applicable FPL to be treated as an applicable taxpayer if (1) the taxpayer or a family member enrolls in a qualified health plan, (2) an Exchange estimates at the time of enrollment that the taxpayer's household income for the taxable year will be between 100 and 400 percent of the applicable FPL, (3) advance credit payments are authorized and paid for one or more months during the taxable year, and (4) the taxpayer would be an applicable taxpayer but for the fact that the taxpayer's household income for the taxable year is below 100 percent of the applicable FPL.

An applicable taxpayer is allowed a premium tax credit for a month only if one or more members of the applicable taxpayer's family is enrolled in one or more qualified health plans through an Exchange and is not eligible for minimum essential coverage in that month. Section 36B(c)(2), § 1.36B–2(a). In general, government-sponsored programs are minimum essential coverage. Section 1.36B–2(c)(1). Under § 1.36B–2(c)(2)(v), an individual is treated as not eligible for Medicaid, the Children's Health Insurance Program (CHIP), or a similar program for a period of coverage under a qualified health

plan if, when the individual enrolls in the qualified health plan, an Exchange determines or considers (within the meaning of 45 CFR 155.302(b)) the individual to be ineligible for such program.

In addition, coverage under an eligible employer-sponsored plan is generally minimum essential coverage.¹ However, an individual who may (but does not) enroll in an employer-sponsored plan is generally considered eligible for that plan only if the plan is considered affordable and provides minimum value. Section 36B(c)(2)(C), § 1.36B–2(c)(3). In addition, under the employee safe harbor in § 1.36B–2(c)(3)(v)(A)(3), an employer-sponsored plan is not considered affordable 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, an Exchange determines that the employer-sponsored plan is not affordable for that plan year.

The existing regulations describing the employee safe harbor contain an exception for reckless disregard for the facts. Under the exception, the safe harbor does not apply in situations in which an Exchange determines that an individual is not eligible for affordable employer-sponsored coverage because an individual, with reckless disregard of the facts, provides incorrect information to the Exchange regarding affordability of the plan.

The proposed regulations add two additional intentional or reckless disregard exceptions to provisions regarding eligibility determinations by the Exchanges. First, to reduce the likelihood that individuals who recklessly or intentionally provide inaccurate information to an Exchange will benefit from the rule in § 1.36B–2(b)(6) (regarding an Exchange determination that the taxpayer's household income for the taxable year will be between 100 and 400 percent of the applicable FPL), the proposed regulations provide that a taxpayer whose household income is below 100 percent of the applicable FPL for the taxpayer's family size does not receive the benefit of that rule if, with

intentional or reckless disregard for the facts, the taxpayer provided incorrect information to an Exchange for the year of coverage.

Second, the proposed regulations provide that an individual who was determined or considered by an Exchange to be ineligible for Medicaid, CHIP, or a similar program (such as a Basic Health Program) does not receive the benefit of the rule in § 1.36B–2(c)(2)(v) (regarding an Exchange determination that an individual was not eligible for coverage under Medicaid, CHIP, or a similar program) if, with intentional or reckless disregard for the facts, the individual (or a person claiming a personal exemption for the individual) provided incorrect information to an Exchange for the year of coverage.

In each of the three instances in the existing and proposed section 36B regulations where an intentional or reckless disregard for the facts exception is provided, the proposed regulations clarify that a reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. The proposed regulations also provide that a disregard of the facts is intentional if the taxpayer knows the information provided to the Exchange is inaccurate.

Commenters asked that the final regulations clarify how the IRS will determine whether an individual has acted with reckless or intentional disregard of the facts, and how these standards will be applied and enforced. Some commenters requested that the final regulations clarify the definition of “reckless disregard” and provide examples. Other commenters expressed concern that the proposed rule would make taxpayers responsible for information provided by third parties who provide assistance with enrollment. Thus, the commenters recommended that the final regulations clarify that an individual is only responsible for information he or she provides to the Exchange and is not responsible for information provided by third parties. The commenters also suggested that the final regulations provide that individuals who use an expert to assist with enrolling in coverage should not be considered to have acted recklessly when relying on the expert's professional advice. Other commenters requested that the final regulations require that individuals be notified of the consequences of potential income-based eligibility fraud.

A commenter also stated that, under the final regulations, the IRS should have the burden of showing that a taxpayer's incorrect information was provided to the Exchange with intentional or reckless disregard for the facts. One commenter suggested that the final regulations clarify that the reckless or intentional disregard for the facts exceptions will be applied on an individual basis. In addition, the commenter asked that the final regulations address how the intentional or reckless disregard for the facts exception, as it applies to the employee safe harbor in § 1.36B–2(c)(3)(v)(A)(3), will be implemented by the Exchanges.

Finally, one commenter requested that the final regulations not adopt the intentional or reckless disregard for the facts exceptions.

After careful consideration of the comments received, the final regulations adopt the intentional or reckless disregard for the facts exception, and the definition of its terms, to the section 36B eligibility safe harbors for household income below 100 percent of the FPL, government programs such as Medicaid, and employer-sponsored coverage. As clarified in the proposed and final regulations, the intentional or reckless disregard for the facts exception applies only when the taxpayer knowingly provides inaccurate information to the Exchange or makes little or no effort to determine whether the information provided is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct of a reasonable person. The commenters' concerns are further addressed in this preamble.

These final regulations, in adopting the intentional or reckless disregard for the facts exceptions set forth in the proposed regulations without modification, do not create new or heightened standards or rules for determining whether a taxpayer acted with intentional or reckless disregard for the facts. Rather, the phrase “intentional or reckless disregard for the facts” as used in the section 36B regulations has a similar meaning and application currently used in other areas of the Code. For example, an intentional or reckless disregard standard also is applied in determining eligibility for other tax credits such as the earned income tax credit and the American opportunity tax credit, see sections 32(k) and 25A(i)(7)(A).

The IRS is responsible for enforcement of the intentional or reckless disregard for the facts exceptions during an examination of a taxpayer's tax return. Thus, the IRS must make the initial showing of facts

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

demonstrating intentional or reckless behavior. Exchanges have no role in enforcing or implementing this standard, although other provisions of law provide Exchanges the authority to impose penalties on individuals who provide incorrect information to an Exchange.

To provide additional clarity, in general, the intentional or reckless disregard for the facts exception only applies to the conduct of the individual attesting to the Exchange. Thus, an individual is only responsible for the information that he or she provides to the Exchange and is not liable for inaccurate information provided by third parties, such as an employer.

An individual's attestations, however, may affect the eligibility of all individuals who are listed on a Marketplace Application for Health Coverage and who the taxpayer intends at the time of enrollment to claim as a dependent. For example, if a taxpayer, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning his household income and receives advance credit payments for coverage of himself and his three dependents, and his actual household income is below 100% of the applicable FPL, then the taxpayer is not an applicable taxpayer and a premium tax credit is not allowed for his coverage or the coverage of his three dependents.

Similarly, many individuals solicit and receive assistance with enrollment and completing the Marketplace Application for Health Coverage. To ensure effective and efficient enrollment through the Exchange, the Department of Health and Human Services uses Navigators, as described at 45 CFR 155.210, to assist potential applicants. In addition, the Marketplaces administer a program for individuals and entities to apply for and receive recognition as a certified application counselor, as defined in 45 CFR 155.225, who may formally offer and provide enrollment assistance to individuals and small businesses. Finally, 45 CFR 155.220 provides standards under which agents and brokers may register and facilitate enrollments through the Marketplaces. Navigators, certified application counselors, agents, and brokers (collectively, authorized advisors) receive comprehensive training on enrollment and completion of a Marketplace Application for Health Coverage, and individuals are encouraged to use them when making enrollment and advance credit payment decisions. Accordingly, for purposes of the final regulations, an individual does

not act recklessly when following the advice of an authorized advisor, so long as the individual provided the authorized advisor with necessary and accurate information. Whether reliance on advice provided by a person other than an authorized advisor is reckless will depend on all of the relevant facts and circumstances, including whether reliance was reasonable and whether the taxpayer provided necessary and accurate information to the other person.

To illustrate, assume Individual D is told by a Navigator that the child support payments D receives from her former spouse are included in her household income in determining whether she is eligible for advance credit payments. Relying on that information, D reports on a Marketplace Application for Health Coverage that her household income for the year of coverage will be over 100 percent of the applicable FPL for D's family size, and D receives the benefit of advance credit payments for the year. When filing her tax return for the year of coverage, D learns that child support payments are not included in her household income for the year of coverage and, thus, her household income is actually under 100 percent of the applicable FPL. D is not considered to have acted with intentional or reckless disregard for the facts because she relied on the advice of a Navigator in providing the information that the Marketplace used to determine whether she was eligible for advance credit payments. Thus, the provision in § 1.36B-2(b)(6) that allows a taxpayer whose household income is below 100 percent of the applicable FPL to be treated as an applicable taxpayer will apply to D despite the fact that her household income for the taxable year is below 100 percent of the applicable FPL.

In contrast, assume Individual E told the Navigator assisting with E's Marketplace Application for Health Coverage that E's lowest-cost option for purchasing self-only employer-sponsored coverage that provides minimum value would cost E \$10,000 for the taxable year, when in fact E knew that he could purchase such coverage for \$5,000. Based on the information E provided, the Navigator advises E that he should indicate on his Marketplace Application for Health Coverage that his required contribution for employer-sponsored coverage is \$10,000. E follows this advice and consequently receives the benefit of advance credit payments for the year. During a subsequent examination, the IRS determines that E could have purchased employer-sponsored

coverage that provides minimum value for \$5,000. For the year of coverage, E is not considered to have reasonably relied on the advice of a Navigator in providing information to the Marketplace because E knowingly provided inaccurate information to the Navigator. Thus, the employee safe harbor in § 1.36B-2(c)(3)(v)(A)(3) does not apply to E.

b. Nonappropriated Fund Health Benefits Program of the Department of Defense

The proposed regulations provide that the Nonappropriated Fund Health Benefits Program of the Department of Defense (the Program) is treated as an eligible employer-sponsored plan for purposes of determining if an individual is eligible for minimum essential coverage under section 36B. This treatment conforms the regulations under section 36B to the regulations under section 5000A, which treat the Program as an eligible employer-sponsored plan. Thus, if coverage under the Program does not provide minimum value (under § 1.36B-2(c)(3)(vi)) or is not considered affordable (under § 1.36B-2(c)(3)(v)) for an individual who does not enroll in the coverage, he or she is not treated as eligible for minimum essential coverage under the Program for purposes of premium tax credit eligibility.

One commenter requested that the final regulations clarify how Marketplaces will determine and verify whether an offer of coverage under the Program provides minimum value and is affordable. In general, employers are required to provide certain information to employees about the coverage that they offer, including information that is relevant to affordability and minimum value. These regulations do not make any changes to those requirements.

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

The existing section 36B regulations provide that an individual is eligible for minimum essential coverage through an eligible employer-sponsored plan if the individual had the opportunity to enroll in the plan and the plan is affordable and provides minimum value. Because in some instances individuals may not be allowed an annual opportunity to decide whether to enroll in eligible employer-sponsored coverage, the proposed regulations provide that if an individual declines to enroll in employer-sponsored coverage for a plan year and does not have the opportunity to enroll in that coverage for one or more succeeding plan years, for purposes of section 36B, the individual

is treated as ineligible for that coverage for the succeeding plan year or years for which there is no enrollment opportunity. This rule relating to eligibility for employer-sponsored coverage is proposed to apply for taxable years beginning after December 31, 2016.²

One commenter sought clarification on how this rule relating to eligibility for employer-sponsored coverage applies to employers with fiscal-year employer plans. The commenter also requests a delay in the effective date to allow additional time for implementation.

The rule in the proposed regulations relating to eligibility for employer-sponsored coverage applies to fiscal year plans in the same manner that it applies to calendar year plans. For example, assume an employer offers an employee affordable, minimum value coverage for a plan year of April 1, 2017 through March 30, 2018. In addition, under the terms of the employer's plan, if the employee declines the coverage beginning on April 1, 2017, the employee is precluded from enrolling for the plan year of April 1, 2018 through March 30, 2019, absent a special enrollment period. Under the proposed regulations, the employee is treated as eligible for this employer-sponsored coverage only for the period between April 1, 2017 and March 31, 2018. Thus, assuming the employee does not enroll in the employer-sponsored coverage through a special enrollment period, the employee is not considered eligible for this employer coverage during the period April 1, 2018 through March 31, 2019.

The final regulations do not adopt the commenter's suggestion to delay the applicability date of the provision relating to eligibility for employer-sponsored coverage to a year after 2017. The Treasury Department and the IRS believe that it would be unfair to employees and their family members who do not have an annual opportunity to enroll in coverage offered to them by an employer to delay the applicability date of this provision. Consequently, the final regulations provide that this

provision is applicable for taxable years beginning after December 31, 2016.

d. Opt-Out Arrangements and An Employee's Required Contribution

The proposed regulations provide rules on the effect of payments made available under opt-out arrangements on an employee's required contribution for purposes of eligibility for the premium tax credit and an exemption from the section 5000A individual shared responsibility provision.³ An opt-out arrangement is an arrangement under which a payment (called an opt-out payment) is made available to an employee by an employer only if the employee declines coverage under an eligible employer-sponsored plan offered by the employer. Prior to the proposed regulations, the Treasury Department and the IRS released Notice 2015–87, 2015–52 I.R.B. 889, which also addressed the effect of opt-out arrangements on an employee's required contribution.

Several comments on the proposed rule were received. The Treasury Department and the IRS continue to examine the issues raised by opt-out arrangements and expect to finalize regulations on the effect of opt-out arrangements on an employee's required contribution at a later time.

As provided in Notice 2015–87, Q&A 9, and reiterated in the proposed rule, the regulations on opt-out arrangements generally will apply only for periods after the applicability of those final regulations. Until those final regulations are applicable, individuals and employers can continue to rely on the guidance provided in Notice 2015–87 and on the proposed rule, including transition relief as clarified and expanded in section 2.f of the preamble to the proposed rule (for opt-out arrangements contained in collective bargaining agreements in effect before December 16, 2015). See 81 FR 44,561.

Accordingly, until the applicability date of final regulations on opt-out arrangements, individuals may treat opt-out payments made available under unconditional opt-out arrangements (as defined in the Background section of the preamble to the proposed regulations (see 81 FR 44,560)) as increasing the employee's required contribution for purposes of sections 36B and 5000A. In addition, for the same period, an individual who can demonstrate that he or she meets the condition(s) (in

addition to declining the employer's health coverage) that must be satisfied to receive an opt-out payment under a conditional opt-out arrangement (as defined in the Background section of the preamble to the proposed regulations (see 81 FR 44,560)), may treat the amount of the conditional opt-out payment as increasing the employee's required contribution for purposes of sections 36B and 5000A.

In contrast, until the applicability date of final regulations on opt-out arrangements, employers are not required to increase an employee's required contribution by the amount of an opt-out payment made available under an opt-out arrangement (other than a payment made available under a non-relief-eligible opt-out arrangement⁴) for purposes of section 6056 (Form 1095–C, Employer-Provided Health Insurance Offer and Coverage), and an opt-out payment made available under an opt-out arrangement (other than a payment made available under a non-relief-eligible opt-out arrangement) will not be treated as increasing an employee's required contribution for purposes of any potential consequences under section 4980H.

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

The proposed regulations provide that if an individual who is enrolled in a qualified health plan for which advance credit payments are made informs the Exchange that the individual is or will soon be eligible for other minimum essential coverage and that advance credit payments should be discontinued, but the Exchange does not discontinue advance credit payments for the first calendar month beginning after the month the individual notifies the Exchange, the individual is treated as eligible for the other minimum essential coverage no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other minimum essential coverage. Similarly, if a determination is made that an individual is eligible for Medicaid or CHIP but advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second

² Note that for purposes of section 4980H, in general, an applicable large employer will not be treated as having made an offer of coverage to a full-time employee for a plan year if the employee does not have an effective opportunity to elect to enroll in the coverage at least once with respect to the plan year. For this purpose, a plan year must be twelve consecutive months, unless a short plan year of less than twelve consecutive months is permitted for a valid business purpose. For additional rules on the definition of "offer" and "plan year" under section 4980H, see §§ 54.4980H–1(a)(35), 54.4980H–4(b), and 54.4980H–5(b).

³ The amount of an employee's required contribution has consequences under section 4980H and the related reporting requirements under section 6056. For more information, see Notice 2015–87, Q&A 7–9 and section 2.f of the preamble to the proposed rule (see 81 FR 44,561).

⁴ For a discussion of non-relief-eligible opt-out arrangements, see Notice 2015–87, Q&A 9 and section 2.f of the preamble of the proposed rule. See 81 FR 44,561.

calendar month beginning after the determination.

Commenters noted that the proposed regulations do not address how the IRS will identify and verify scenarios in which an individual requested prospective discontinuation of advance credit payments but there was a delay in the discontinuation. The commenters also pointed out that consumers may request an accelerated termination if the Exchange and health plan issuer allow it and the proposed regulations do not address how these scenarios will be handled. Consequently, the commenters requested that the IRS issue clear instructions and guidance for taxpayers and tax preparers for situations in which there is a delay discontinuing or terminating advance credit payments to ensure that taxpayers will not be subject to penalties or repayment of advance credit payments for which they are not responsible.

The Instructions to Form 8962, Premium Tax Credit (PTC), and Publication 974, Premium Tax Credit, will include a discussion of this rule concerning eligibility for certain non-Marketplace minimum essential coverage when the discontinuance of advance credit payments is delayed. Furthermore, the IRS intends to, in Questions and Answers on www.irs.gov, address situations in which there is a delay in the discontinuance of advance credit payments and the taxpayer is allowed a premium tax credit for a month for which the taxpayer receives a Form 1095-B or Form 1095-C showing that the taxpayer was enrolled in non-Marketplace minimum essential coverage.

Commenters requested that the final regulations acknowledge that this rule concerning eligibility for non-Marketplace minimum essential coverage when there has been a delay in the discontinuance of advance credit payments does not change the obligations of health plan issuers for prior years, notwithstanding that the rule in the proposed regulations may be relied on by taxpayers for taxable years beginning after December 31, 2013. Although the obligations of health plan issuers are generally outside the scope of these regulations, it is the understanding of the Treasury Department and the IRS, in consultation with the Department of Health and Human Services (HHS), that this rule regarding when an individual is eligible for certain non-Marketplace coverage does not affect the obligations of health plan issuers or the deadlines imposed by or on those issuers.

One commenter requested that the rule extend to other situations, such as

when an individual receiving the benefit of advance credit payments is incarcerated after disposition of charges. Under section 1312(f)(1)(B) of the Affordable Care Act (42 U.S.C. 18032(f)(1)(B)), incarcerated individuals may not be enrolled through a Marketplace. However, unlike an individual enrolled in minimum essential coverage outside of the Marketplace, if there is a delay in disenrolling the incarcerated individual and discontinuing the advance credit payments, neither section 36B nor its regulations prohibit a taxpayer from claiming a premium tax credit for an incarcerated individual's Marketplace coverage. Thus, the final regulations do not adopt this comment.

The same commenter also requested a change in the rule concerning delays in discontinuance of advance credit payments after a Medicaid or CHIP determination. Under the proposed regulations, if there is a delay in discontinuance of advance credit payments following a Medicaid or CHIP eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the determination. The commenter stated that, under the final regulations, an individual should be treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination is communicated to the Exchange.

The final regulations do not adopt this comment. The commenter is likely concerned about a situation in which the office that made a Medicaid or CHIP determination for an individual does not promptly notify the Marketplace of that status and the individual remains enrolled in Marketplace coverage with advance credit payments for multiple months. However, individuals enrolled in Marketplace coverage with advance credit payments who are determined eligible for Medicaid or CHIP should also promptly notify their Marketplace to discontinue the advance credit payments. Amending the rule to delay eligibility until the second month after the determination is communicated to the Marketplace effectively allows individuals who fail to promptly communicate with their Marketplaces to be dual enrolled for multiple months with advance credit payments.

2. Premium Assistance Amount

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

Under existing § 1.36B-3(c)(1)(ii), a month is a coverage month for an individual only if the share of the premium for the individual's coverage for the month not covered by advance credit payments is paid by the unextended due date of the income tax return for the year of coverage of the taxpayer claiming a personal exemption for the individual.

As discussed in the preamble to the proposed regulations, instances arise in which an individual is initially determined ineligible for advance credit payments, does not enroll in a qualified health plan pending the individual's appeal of the determination, and is later determined to be eligible for advance credit payments through the appeals process. If the individual then elects to be retroactively enrolled in an Exchange health plan, the deadline for paying premiums for the retroactive coverage may be after the unextended due date for filing an income tax return for the year of coverage. To address this issue, the proposed regulations provide that a taxpayer who is eligible for advance credit payments pursuant to an eligibility appeal for a member of the taxpayer's coverage family who, based on the appeals decision, retroactively enrolls in a qualified health plan, is considered to have met the requirement in § 1.36B-3(c)(1)(ii) for a month if the taxpayer pays the individual's share of the premium for coverage under the plan for the month on or before the 120th day following the date of the appeals decision (the appeal premium payment period).

A commenter opined that to ensure accurate and consistent identification and reporting of payment deadlines, the triggering event that begins the appeal premium payment period under the section 36B regulations should align with the triggering event provided in 45 CFR 155.400(e)(1)(iii), which provides as follows: "For coverage to be effectuated under retroactive effective dates, . . . the deadline for making the binder payment must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction." The commenter notes that the date the appeal premium payment period begins under the proposed regulations (the date of the appeals decision) is different from the date the period begins under 45 CFR 155.400(e)(1)(iii) (the date the issuer receives the enrollment transaction) and suggests that the final regulations

conform to the language in 45 CFR 155.400(e)(1)(iii) because qualified health plan issuers would not know the date of the appeals decision and would not know whether the premium payment was made within 120 days of the appeals decision. The commenter also opined that the 120-day period in the proposed regulations may be too long for some retroactive enrollment scenarios, such as a situation in which an individual is enrolled in retroactive coverage for only a few months. The commenter also suggested that the appeal premium payment rule in the section 36B regulations should apply only in situations in which the appeal decision is after the individual's unextended due date for filing an income tax return for the year of coverage.

The final regulations do not adopt the suggested changes. The purpose of the appeal premium payment period in the section 36B regulations is to ensure that taxpayers who pay their premiums within a reasonable time following a favorable appeal decision may qualify for a premium tax credit. On the other hand, the payment date rule in 45 CFR 155.400(e)(1)(iii) relates to when the payment must be made to effectuate the retroactive coverage. Qualified health plan issuers need to know the date they received the enrollment transaction and thus whether the premium payments were timely made to effectuate the retroactive coverage, but have no need to know whether the payments were made within 120 days of the appeal decision. In addition, the 120-day period is needed to provide equitable treatment, whether the appeal decision is before or after the unextended due date for filing an income tax return for the year of coverage. It would be inequitable to allow a taxpayer who gets a favorable appeal decision five days after the unextended due date of his or her tax return the benefit of the 120-day appeal premium payment period but not extend the same benefit to a taxpayer who gets an appeal decision five days before the unextended due date.

3. Benchmark Plan Premium

a. Pediatric Dental Benefits

Under the existing section 36B regulations, if a member of a taxpayer's coverage family is enrolled in a stand-alone dental plan, the portion of the monthly premium for the stand-alone dental plan allocable to pediatric dental benefits is added to the taxpayer's monthly enrollment premium in determining the taxpayer's premium assistance amount for the month. Under the existing regulations, however, the

portion of the monthly premium for a stand-alone dental plan allocable to pediatric dental benefits does not affect the taxpayer's applicable benchmark plan premium.

Because the existing regulations frustrate the goal of section 36B of making coverage for essential health benefits affordable to individuals eligible for the premium tax credit, the proposed regulations provide that, if an Exchange offers one or more silver-level qualified health plans that do not include pediatric dental benefits, the applicable benchmark plan is determined by ranking (1) the premiums for the silver-level qualified health plans that include pediatric dental benefits offered by the Exchange and (2) the aggregate of the premiums for the silver-level qualified health plans offered by the Exchange that do not include pediatric dental benefits plus the portion of the premium allocable to pediatric dental benefits for stand-alone dental plans offered by the Exchange. In constructing this ranking, the premium for the lowest-cost silver plan that does not include pediatric dental benefits is added to the premium allocable to pediatric dental benefits for the lowest cost stand-alone dental plan, and similarly, the premium for the second lowest-cost silver plan that does not include pediatric dental benefits is added to the premium allocable to pediatric dental benefits for the second lowest-cost stand-alone dental plan. The second lowest-cost amount from this combined ranking of premiums is the taxpayer's applicable benchmark plan premium. Finally, the proposed regulations provide that the rule for determining the applicable benchmark plan for situations in which an Exchange offers one or more silver-level qualified health plans that do not cover pediatric dental benefits (the pediatric dental rule) is applicable for taxable years beginning after December 31, 2018.

One commenter noted that the effect of the rule in the proposed regulations relating to pediatric dental benefits is that some taxpayers will have a lower monthly premium assistance amount as compared to their monthly premium assistance amount under the existing section 36B regulations. In particular, the commenter pointed to Example 4 of § 1.36B–3(f)(9) of the proposed regulations in which the taxpayer's benchmark plan premium is lower under the rules of the proposed regulations than under the existing section 36B regulations. Under this example, the applicable benchmark plan premium would be based on the lowest-cost rather than the second-lowest-cost

silver-level qualified health plan. The commenter suggested that this is likely not a result intended by the Treasury Department and the IRS and recommended that the final regulations include a revision to the language of the proposed regulations to fix this unintended result.

The final regulations adopt the recommendation in this comment. Under the final regulations, if one or more silver-level qualified health plans offered through an Exchange do not cover pediatric dental benefits, the premium for the applicable benchmark plan is determined based on the second lowest-cost option among (i) the silver-level qualified health plans that are offered by the Exchange to the members of the coverage family and that provide pediatric dental benefits; and (ii) the silver-level qualified health plans that are offered by the Exchange to the members of the coverage family that do not provide pediatric dental benefits in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan (within the meaning of section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 18031(d)(2)(B)(ii)) offered by the Exchange to the members of the coverage family that is properly allocable to pediatric dental benefits. Thus, under the final regulations, if a taxpayer's coverage family is able to enroll in one or more silver-level qualified health plans that do not provide pediatric dental benefits, the second lowest-cost portion of the premium for a stand-alone dental plan offered by the Exchange to the members of the coverage family that is properly allocable to pediatric dental benefits is added to the premium for each of those silver-level plans in determining the taxpayer's applicable benchmark plan.

One commenter requested clarification on how to determine the portion of the premium of a stand-alone dental plan properly allocable to the cost of pediatric dental benefits. According to the commenter, the portion of a plan's premium that is allocable to each essential health benefit (EHB) is determined by using an EHB factor (a multiplier that applies to the plan and represents the portion of the total benefit package that represents the EHB), and the EHB factor does not change based on who is purchasing the plan and what benefits they are eligible to use. The commenter asks for clarification on if, and how, an EHB factor is to be applied to a stand-alone dental plan and whether a stand-alone dental plan should have a different EHB factor apply based on whether children, or only adults, are enrolled in the plan.

The determination of the portion of the premium of a stand-alone dental plan properly allocable to pediatric dental benefits is outside the scope of these regulations. However, HHS has confirmed that, under its guidance, if no members of a taxpayer's coverage family are eligible for pediatric dental benefits, the portion of the premium allocable to pediatric dental benefits for all stand-alone dental plans the family may enroll in is \$0.

Another commenter stated that the pediatric dental rule in the proposed regulations is inconsistent with the provisions of section 36B. Specifically, the commenter contends that the clear meaning of section 36B(b)(3)(E) is that the portion of a stand-alone pediatric dental plan premium allocable to pediatric dental benefits is added only to the enrollment premium, not the benchmark plan premium, in computing the premium tax credit, and is added only for taxpayers who have a family member who enrolls in a stand-alone dental plan. In addition, the commenter opines that the pediatric dental rule in the proposed regulations is overly complex and provides minimal benefit to a small group of taxpayers.

The Treasury Department and the IRS disagree that the pediatric dental rule is inconsistent with the provisions of section 36B. Although, as noted by the commenter, section 36B(b)(3)(E) relates only to the portion of a stand-alone dental plan premium that is added to a taxpayer's enrollment premium, the proposed regulations do not rely upon an interpretation of section 36B(b)(3)(E). Rather, as discussed in the preamble of the proposed regulations, the pediatric dental rule is based on statutory references to "self-only coverage" and "family coverage" in section 36B(b)(3)(B)(ii), and is consistent with the overall goal of section 36B, which is to make affordable the coverage of each of the essential health benefits described in section 1302(b) of the Affordable Care Act for individuals eligible for a premium tax credit. As discussed, that coverage may be obtained from either a qualified health plan covering all of the essential health benefits or one covering all benefits except pediatric dental in combination with a stand-alone dental plan. Finally, although the pediatric dental rule does add some complexity to the determination of a taxpayer's applicable benchmark plan, the rule will, in general, not result in more complexity to taxpayers because they generally use the benchmark plan premium amount reported to them by Exchanges to compute their premium tax credit. In addition, the pediatric dental rule in the final regulations,

which, for stand-alone dental plans, considers just the second lowest-cost portion of the premium properly allocable to pediatric dental benefits in the determination of a taxpayer's applicable benchmark plan, is less complex than the rule in the proposed regulations, which requires consideration of both the lowest-cost and the second lowest-cost portion.

Other commenters supported the pediatric dental rule and asked that taxpayers be allowed to compute their applicable benchmark plan using the pediatric dental rule in the proposed regulations for taxable years beginning before January 1, 2019. However, taxpayers must know their benchmark plan premium amount to properly compute their premium tax credit and, consequently, Exchanges must provide this information to taxpayers. Because this pediatric dental rule involves a change in the manner in which a taxpayer's applicable benchmark plan is determined, Exchanges need time to implement the new rule and have indicated that they are likely unable to do so for taxable years beginning before January 1, 2019. Consequently, the final regulations do not adopt this comment.

b. Members of Coverage Family Residing in Different States

Under existing § 1.36B-3(f)(4), if members of a taxpayer's family reside in different states and enroll in separate qualified health plans, the premium for the taxpayer's applicable benchmark plan is the sum of the premiums for the applicable benchmark plans for each group of family members living in the same state. Because this rule may not accurately reflect the cost of available coverage for a taxpayer whose family members reside in different locations in the same state, the proposed regulations provide that if members of a taxpayer's coverage family reside in different locations, whether within the same state or in different states, the taxpayer's benchmark plan premium is the sum of the premiums for the applicable benchmark plans for each group of coverage family members residing in different locations, based on the plans offered to the group through the Exchange for the rating area where the group resides. The proposed regulations provide that the rules for calculating the premium tax credit operate the same for families residing in multiple locations within a state and families residing in multiple states.

One commenter expressed concern that the rule in the proposed regulations concerning the benchmark plan premium for members of the coverage family residing in different locations

could result in unequal treatment of separate families, particularly in Marketplaces in which there are many rating areas within a relatively small geographic area and numerous plans are available for enrollment in many or all rating areas. Thus, the commenter asked that Marketplaces be allowed to use their own benchmark plan rating methodology rather than the rule in the proposed regulations for members of the coverage family who reside in different locations within a state.

The final regulations do not adopt this comment. The amount of a taxpayer's premium tax credit depends on the taxpayer's applicable benchmark plan and the premium for that plan. Allowing Exchanges to use different methodologies to determine the benchmark plan premium could result in inequitable treatment of taxpayers in different locations. One Exchange's methodology would undoubtedly provide a more generous benchmark plan premium for taxpayers who enroll in a qualified health plan through that Exchange as compared to taxpayers who enroll through another Exchange using a different methodology.

Another commenter asked that the final regulations clarify how the rule relating to family members residing in different locations works for farm workers who frequently migrate to find agricultural work, especially those who stay enrolled in the same plan despite the relocations. The rule concerning family members residing in different locations has no unique effect for individuals who frequently move to new locations and thus the final regulations include no new rules addressing this situation. HHS regulations at 45 CFR 155.335(e) require individuals who move to a new rating area to inform the Exchange in the new rating area of their move. The move may require a recomputation of the individual's advance credit payments, or perhaps necessitate the individual to enroll in a new qualified health plan, both of which are determined by the Exchange in the new rating area.

c. Aggregation of Silver-level Policies

Existing § 1.36B-3(f)(3) provides that if one or more silver-level plans offered through an Exchange do not cover all members of a taxpayer's coverage family under one policy (for example, because an issuer will not cover a taxpayer's dependent parent on the same policy the taxpayer enrolls in), the premium for the applicable benchmark plan may be the premium for a single policy or for more than one policy, whichever is the second lowest-cost silver option. Because this rule is complex for

taxpayers and difficult for Exchanges and the IRS to administer, the proposed regulations delete the existing rule and provide a new rule in its place. Under the proposed regulations, if a silver-level plan offers coverage to all members of a taxpayer's coverage family who reside in the same location under a single policy, the plan premium taken into account for purposes of determining the applicable benchmark plan is the premium for that policy. However, if a silver-level plan would require multiple policies to cover all members of a taxpayer's coverage family who reside in the same location, the plan premium taken into account for purposes of determining the applicable benchmark plan is the sum of the premiums for self-only policies under the plan for each member of the coverage family who resides in the same location. The proposed regulations also requested comments on an alternative rule under which the sum of the premiums for self-only policies under a plan for each member of the taxpayer's coverage family would always be used to determine a taxpayer's applicable benchmark plan.

One commenter asked that the final regulations adopt the alternative rule discussed in the preamble to the proposed regulations concerning the determination of a taxpayer's applicable benchmark plan, not the rules in the proposed regulations, which vary based on whether a single policy or multiple policies are needed to cover a taxpayer's family. The commenter opined that this alternative rule has the potential to streamline the applicable benchmark plan calculation with minimal impact to the amount of premium tax credit a taxpayer is allowed.

The final regulations do not adopt this comment. Under HHS regulations, the qualified health plan premium for a taxpayer with three dependents is not increased by adding one or more additional dependents to the taxpayer's family. 45 CFR 147.102(c)(1). That is, the portion of the premium due to the taxpayer's dependents is capped at three dependents and does not increase as a result of adding more dependents to the family. However, if the alternative rule suggested by the commenter is adopted, a taxpayer with four or more dependents would have a higher benchmark plan premium than a similarly-situated taxpayer with three dependents even though the additional dependents do not add to the cost of the coverage for the taxpayer with four or more dependents. Thus, aggregating the sum of the self-only policies under a plan for each member of a taxpayer's coverage family may provide an undue

benefit to taxpayers with four or more dependents. Accordingly, this approach should be limited to situations in which a silver-level plan requires multiple policies to cover all members of a taxpayer's coverage family who reside in the same location.

d. Effective/Applicability Dates

Under the proposed regulations, the changes to the rules concerning the determination of a taxpayer's applicable benchmark plan are proposed to be applicable for tax years beginning after December 31, 2018. Commenters noted that State-based Marketplaces often have very different eligibility and enrollment systems from the Federally-Facilitated Marketplace and from each other, and the changes to the applicable benchmark plan rules will require significant changes to their systems and long timelines for implementation. Consequently, the commenters asked that the Treasury Department and the IRS provide flexibility to State-based Marketplaces and provide ample time between the effective date of the final regulations and the date the states must implement the benchmark plan changes.

The final regulations do not alter the applicability date for the rule for computing the benchmark plan. Doing so would permit inequitable treatment of taxpayers in different locations and potentially have an adverse impact on certain taxpayers. Thus, the final regulations provide that the changes to the benchmark plan rules are applicable for taxable years beginning after December 31, 2018.

4. Information Reporting

The proposed regulations provide that when multiple families enroll in a single qualified health plan and advance credit payments are made for the coverage, the enrollment premiums reported by the Exchange for each family are the family's allocable share of the enrollment premiums, which is based on the proportion of each family's applicable benchmark plan premium. One commenter requested clarification that this reporting rule applies only in situations in which a taxpayer requests financial assistance through advance credit payments or cost-sharing reductions, or is seeking to enroll in Medicaid. The final regulations, like the proposed regulations, provide that the Exchange must report a portion of the plan's enrollment premium to each enrolled family if multiple families enroll in a single qualified health plan and advance credit payments are made for coverage under the plan. The portion reported is based on the proportion of

each family's applicable benchmark plan premium.

The proposed regulations also provide that, if an individual's coverage in a qualified health plan is terminated before the last day of a month, or if an individual is enrolled in coverage after the first day of a month and the coverage is effective on the date of the individual's birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order, an Exchange must report the enrollment premiums for the month (excluding the premium allocated to benefits in excess of essential health benefits), reduced by any amount that was refunded because the enrollment was for less than a full month. This reporting requirement was proposed to apply for taxable years beginning after December 31, 2016.

One commenter expressed concern with the rule requiring that Exchanges reduce the reported enrollment premium by any amounts of the enrollment premiums that are refunded by the issuer of the qualified health plan. The commenter stated that this requirement is not something that currently is captured by its reporting system, and updating the system would require an effort that would be out of scale with the small size of the population enrolled for less than a full month. The commenter suggests that refund information could be obtained when a taxpayer computes his or her premium tax credit on the taxpayer's Federal income tax return.

Alternatively, the commenter requested that this requirement become effective for a taxable year later than 2017. To provide enrollment systems additional time to implement the updates and system modifications necessary to accurately report refunds for partial months of coverage, the final regulations delay the applicability date for this rule by two years, so that it applies for taxable years beginning after December 31, 2018. Exchanges able to comply with the reporting rule before that date are encouraged to do so.

Effective/Applicability Date

Except as otherwise provided, these final regulations apply for taxable years beginning after December 31, 2016. The rules relating to the benchmark plan premium described in section 3 of this preamble and the rules relating to reporting by the Exchanges described in section 4 of this preamble apply for taxable years beginning after December 31, 2018. As discussed in the Effective/Applicability Date section of the preamble to the proposed regulations, taxpayers may rely on certain provisions

of the proposed regulations for taxable years ending after December 31, 2013.

See section 1.d of this preamble for a discussion of the effective date/applicability date for proposed regulations regarding opt-out arrangements.

Special Analyses

Certain IRS regulations, including these, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory assessment is not required.

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

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

Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking that preceded this regulation was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business. No comments were received.

Drafting Information

The principal authors of these proposed regulations are Lisa Mojiri-Azad, Shareen S. Pflanz, and Stephen J. Toomey of the Office of Associate Chief Counsel (Income Tax and Accounting). However, other personnel from the IRS and the Treasury Department participated in the development of the regulations.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 301

Employment taxes, Estate taxes, Excise taxes, Gift taxes, Income taxes,

Penalties, Reporting and recordkeeping requirements.

Amendments to the Regulations

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

PART 1—INCOME TAXES

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

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

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

- 1. Adding the entries for § 1.36B–2(b)(6)(i) and (ii).
- 2. Redesignating entry for § 1.36B–2(c)(4) as (c)(5) and adding new entries for § 1.36B–2(c)(3)(v)(A)(7), (c)(4), (c)(4)(i), (c)(4)(ii), (c)(4)(ii)(A), (c)(4)(ii)(B), (c)(5), (d), and (e).
- 3. Redesignating entry for § 1.36B–3(c)(4) as (c)(5) and adding a new entry for § 1.36B–3(c)(4).
- 4. Revising entries for § 1.36B–3(d)(1) and (2).
- 5. Revising entries for § 1.36B–3(f)(3), (4), and (5).
- 6. Adding entries for § 1.36B–3(f)(5)(i) and (ii).
- 7. Revising entries for § 1.36B–3(f)(6) and (7).
- 8. Adding entries for § 1.36B–3(f)(8), (f)(9), (m), and (n).
- 9. Adding entries for § 1.36B–5(c)(3)(iii), (c)(3)(iii)(A), and (c)(3)(iii)(B).

The revisions and additions read as follows:

§ 1.36B–0 Table of contents.

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§ 1.36B–2 Eligibility for premium tax credit.

* * * * *

(b) * * *

(6) * * *

(i) In general.

(ii) Exceptions.

* * * * *

(c) * * *

(3) * * *

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(A) * * *

(7) Opt-out arrangements.

* * * * *

(4) Special eligibility rules.

(i) Related individual not claimed as a personal exemption deduction.

(ii) Exchange unable to discontinue advance credit payments.

(A) In general.

(B) Medicaid or CHIP.

(5) Related individuals not claimed as a personal exemption deduction.

(d) [Reserved]

(e) Effective/applicability dates.

* * * * *

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

* * * * *

(c) * * *

(4) Appeals of coverage eligibility.

(d) * * *

(1) Premium assistance amount.

(2) Examples.

* * * * *

(f) * * *

(3) Silver-level plan not covering pediatric dental benefits.

(4) Family members residing in different locations.

(5) Single or multiple policies needed to cover the family.

(i) Policy covering a taxpayer's family.

(ii) Policy not covering a taxpayer's family.

(6) Plan not available for enrollment.

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

(8) Only one silver-level plan offered to the coverage family.

(9) Examples.

* * * * *

(m) [Reserved]

(n) Effective/applicability date.

§ 1.36B–5 Information reporting by Exchanges.

* * * * *

(c) * * *

(3) * * *

(iii) Partial month of coverage.

(A) In general.

(B) Certain mid-month enrollments.

* * * * *

■ **Par. 3.** Section 1.36B–1 is amended by revising paragraphs (l), (m), and (o) to read as follows:

§ 1.36B–1 Premium tax credit definitions.

* * * * *

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

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

* * * * *

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

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

- 1. Revising paragraph (b)(6) introductory text and paragraphs (b)(6)(i) and (ii).
- 2. Adding three sentences to the end of paragraph (c)(2)(v).
- 3. Revising paragraph (c)(3)(i).
- 4. Revising paragraph (c)(3)(iii)(A).
- 5. Removing the sentence at the end of the paragraph (c)(3)(v)(A)(3) and adding in its place three new sentences.
- 6. Adding paragraph (c)(3)(v)(A)(7).
- 7. Revising paragraph (c)(4).
- 8. Removing and reserving paragraph (d).
- 9. Adding paragraph (e).

The revisions and additions read as follows:

§ 1.36B–2 Eligibility for premium tax credit.

* * * * *

(b) * * *

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

(A) The taxpayer or a family member enrolls in a qualified health plan through an Exchange for one or more months during the taxable year;

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

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

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

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

taxpayer knows the information provided to the Exchange is inaccurate.

* * * * *

(c) * * *

(2) * * *

(v) * * * This paragraph (c)(2)(v)

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

* * * * *

(3) * * *

(i) *In general.* For purposes of section 36B, an employee who may enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2) and the regulations under that section) that is minimum essential coverage, and an individual who may enroll in the plan because of a relationship to the employee (a related individual), are eligible for minimum essential coverage under the plan for any month only if the plan is affordable and provides minimum value. Except for the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 1587 note), government-sponsored minimum essential coverage is not an eligible employer-sponsored plan. The Nonappropriated Fund Health Benefits Program of the Department of Defense is considered eligible employer-sponsored coverage, but not government-sponsored coverage, for purposes of determining if an individual is eligible for minimum essential coverage under this section.

* * * * *

(iii) * * *

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

one or more succeeding plan years, this paragraph (c)(3)(iii)(A) applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

* * * * *

(v) * * *

(A) * * *

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

* * * * *

(7) *Opt-out arrangements.* [Reserved]

* * * * *

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

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

(B) *Medicaid or CHIP.* If a determination is made that an individual who is enrolled in a qualified

health plan for which advance credit payments are made is eligible for Medicaid or CHIP but the advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for the Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination.

(d) [Reserved]

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

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

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

■ 1. Redesignating paragraph (c)(4) as paragraph (c)(5) and adding a new paragraph (c)(4).

■ 2. Revising paragraph (d)(1).

■ 3. Revising paragraph (d)(2).

■ 4. Revising paragraph (f).

■ 5. Adding paragraph (n).

The revisions and additions read as follows:

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

* * * * *

(c) * * *

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

* * * * *

(d) * * *

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

(i) The premiums for the month, reduced by any amounts that were refunded, for one or more qualified health plans in which a taxpayer or a member of the taxpayer's family enrolls (enrollment premiums); or

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

(2) *Examples.* The following examples illustrate the rules of paragraph (d)(1) of this section.

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

Example 2. (i) Taxpayer R is single and has no dependents. R enrolls in a qualified health plan with a monthly premium of \$450. The difference between R's benchmark plan premium and contribution amount for the month is \$420.

(ii) The issuer of R's qualified health plan is notified that R died on September 20. The issuer terminates coverage as of that date and refunds the remaining portion of the September enrollment premiums (\$150) for R's coverage.

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

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

* * * * *

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

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

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

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

(ii) Family coverage for all other taxpayers.

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

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

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

(ii) The silver-level qualified health plans that are offered by the Exchange to the members of the coverage family that do not provide pediatric dental benefits in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan (within the meaning of section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 18031(d)(2)(B)(ii)) offered by the Exchange to the members of the coverage family that is properly allocable to pediatric dental benefits determined under guidance issued by the Secretary of Health and Human Services.

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

taxpayer's coverage family for the rating area where the coverage family resides.

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

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

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

(7) *Benchmark plan terminates or closes to enrollment during the year*. A silver-level qualified health plan or a stand-alone dental plan that is used for purposes of determining the applicable benchmark plan under this paragraph (f) for a taxpayer does not cease to be the applicable benchmark plan for a taxable year solely because the plan or a lower cost plan terminates or closes to enrollment during the taxable year.

(8) *Only one silver-level plan offered to the coverage family*. If there is only one silver-level qualified health plan or one stand-alone dental plan offered through an Exchange that would cover all members of a taxpayer's coverage family who reside in the same location (whether under one policy or multiple policies), that plan is used for purposes of determining the taxpayer's applicable benchmark plan.

(9) *Examples*. The following examples illustrate the rules of this paragraph (f). Unless otherwise stated, in each

example the plans are open to enrollment to a taxpayer or family member at the time of enrollment and are offered through the Exchange for the rating area where the taxpayer resides:

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

Example 2. Single taxpayer enrolls with dependent child through an Exchange where all qualified health plans provide pediatric dental benefits. Taxpayer B is single and claims her 12-year old daughter, C, as a dependent. B purchases family coverage for herself and C. The Exchange in the rating area in which B and C reside offers qualified health plans that provide pediatric dental benefits but does not offer qualified health plans without pediatric dental benefits. Under paragraphs (f)(1) and (f)(2) of this section, B's applicable benchmark plan is the second lowest-cost silver plan providing family coverage to B and C.

Example 3. Single taxpayer enrolls with dependent child through an Exchange where one or more qualified health plans do not provide pediatric dental benefits. (i) Taxpayer D is single and claims his 10-year old son, E, as a dependent. The Exchange in the rating area in which D and E reside offers three silver-level qualified health plans, one of which provides pediatric dental benefits (S1) and two of which do not (S2 and S3), in which D and E may enroll. The Exchange also offers two stand-alone dental plans (DP1 and DP2) available to D and E. The monthly premiums allocable to essential health benefits for the silver-level plans are as follows:

S1—\$650
S2—\$620
S3—\$590

(ii) The monthly premiums, and the portion of the premium allocable to pediatric dental benefits, for the two dental plans are as follows:

DP1—\$50 (\$20 allocable to pediatric dental benefits)
DP2—\$40 (\$15 allocable to pediatric dental benefits).

(iii) Under paragraph (f)(3) of this section, D's applicable benchmark plan is the second lowest cost option among the following offered by the rating area in which D resides: Silver-level qualified health plans providing pediatric dental benefits (\$650 for S1) and the silver-level qualified health plans not providing pediatric dental benefits, in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits (\$590 for S3 in conjunction with \$20 for DP1 = \$610 and \$620 for S2 in conjunction with \$20 for DP1 = \$640). Under paragraph (e) of this section, the adjusted monthly premium for D's applicable benchmark plan is \$640.

Example 4. Single taxpayer enrolls with dependent adult through an Exchange where one or more qualified health plans do not provide pediatric dental benefits. (i) The facts are the same as in Example 3, except Taxpayer D's coverage family consists of D and D's 22-year old son, F, who is a dependent of D. The monthly premiums allocable to essential health benefits for the silver-level plans are as follows:

S1—\$630
S2—\$590
S3—\$580

(ii) Because no one in D's coverage family is eligible for pediatric dental benefits, \$0 of the premium for a stand-alone dental plan is allocable to pediatric dental benefits in determining A's applicable benchmark plan. Consequently, under paragraphs (f)(1), (f)(2), and (f)(3) of this section, D's applicable benchmark plan is the second lowest-cost option among the following options offered by the rating area in which D resides: Silver-level qualified health plans providing pediatric dental benefits (\$630 for S1) and the silver-level qualified health plans not providing pediatric dental benefits, in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits (\$580 for S3 in conjunction with \$0 for DP1 = \$580 and \$590 for S2 in conjunction with \$0 for DP1 = \$590). Under paragraph (e) of this section, the adjusted monthly premium for D's applicable benchmark plan is \$590.

Example 5. Single taxpayer enrolls with dependent and nondependent. Taxpayer G is single and resides with his 25-year old daughter, H, and with his 14-year old son, I. G may claim I, but not H, as a dependent. G, H, and I enroll in coverage through the Exchange in the rating area in which they all reside. The Exchange offers only silver-level plans providing pediatric dental benefits. Under paragraphs (f)(1) and (f)(2) of this section, G's applicable benchmark plan is the second lowest-cost silver plan covering G and I. However, H may qualify for a premium tax credit if H is otherwise eligible. See paragraph (h) of this section.

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

Example 7. Minimum essential coverage for some coverage months. Taxpayer L claims his 6-year old daughter, M, as a dependent. L and M are enrolled for the entire year in a qualified health plan that offers only silver-level plans that provide pediatric dental benefits. L, but not M, is eligible for government-sponsored minimum essential

coverage for September to December. Thus, under paragraph (c)(1)(iii) of this section, January through December are coverage months for M, and January through August are coverage months for L. Because, under paragraphs (d) and (f)(1) of this section, the premium assistance amount for a coverage month is computed based on the applicable benchmark plan for that coverage month, L's applicable benchmark plan for January through August is the second lowest-cost option covering L and M. Under paragraph (f)(1)(i)(C) of this section, L's applicable benchmark plan for September through December is the second lowest-cost silver plan providing self-only coverage for M.

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

Example 9. Benchmark plan premium for a coverage family with family members who reside in different locations. (i) Taxpayer N's coverage family consists of N and her three dependents O, P, and Q. N, O, and P reside together but Q resides in a different location. The monthly applicable benchmark plan premium for N, O, and P is \$1,000 and the monthly applicable benchmark plan premium for Q is \$220.

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

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

(ii) Under paragraph (f)(5) of this section, Issuer C's silver-level plan that covers R, S, and T under one policy (\$1,200 monthly premium) and Issuer A's and Issuer B's silver-level plans that do not cover R, S and T under one policy are considered in

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

Example 11. Benchmark plan premium for a taxpayer with family members who cannot enroll in one policy and who reside in different locations. (i) Taxpayer U's coverage family consists of U, U's mother, V, and U's two daughters, W and X. U and V reside together in Location 1 and W and X reside together in Location 2. The Exchange in the rating area in which U and V reside does not offer a silver-level plan that covers U and V under a single policy, whereas all the silver-level plans offered through the Exchange in the rating area in which W and X reside cover W and X under a single policy. Both Exchanges offer only silver-level plans that provide pediatric dental benefits. The silver plan offered by the Exchange for the rating area in which U and V reside that would cover U and V under self-only policies with the second-lowest aggregate premium costs \$400 a month for self-only coverage for U and \$600 a month for self-only coverage for V. The monthly premium for the second-lowest cost silver plan covering W and X that is offered by the Exchange for the rating area in which W and X reside is \$500.

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

Example 12. Qualified health plan closed to enrollment. Taxpayer Y has two dependents, Z and AA. Y, Z, and AA enroll in a qualified health plan through the Exchange for the rating area where the family

resides. The Exchange, which offers only qualified health plans that include pediatric dental benefits, offers silver-level plans J, K, L, and M, which are, respectively, the first, second, third, and fourth lowest cost silver plans covering Y's family. When Y's family enrolls, Plan J is closed to enrollment. Under paragraph (f)(6) of this section, Plan J is disregarded in determining Y's applicable benchmark plan, and Plan L is used in determining Y's applicable benchmark plan.

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

(ii) Under paragraphs (f)(1), (f)(2), (f)(3), and (f)(7) of this section, the silver-level plan that BB and CC use to determine their applicable benchmark plan for all coverage months during the year is Plan 2. The applicable benchmark plan that DD uses to determine DD's applicable benchmark plan is Plan 3, because Plan 2 is not open to enrollment through the Exchange when the DD family enrolls.

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

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

* * * * *

(n) *Effective/applicability date.* (1) Except as provided in paragraph (n)(2) of this section, this section applies to

taxable years ending after December 31, 2013.

(2) Paragraphs (c)(4), (d)(1) and (d)(2) of this section apply to taxable years beginning after December 31, 2016.

Paragraph (f) of this section applies to taxable years beginning after December 31, 2018. Paragraphs (d)(1) and (d)(2) of § 1.36B–3, as contained in 26 CFR part I edition revised as of April 1, 2016, applies to taxable years ending after December 31, 2013, and beginning before January 1, 2017. Paragraph (f) of § 1.36B–3, as contained in 26 CFR part I edition revised as of April 1, 2016, applies to taxable years ending after December 31, 2013, and beginning before January 1, 2019.

■ **Par. 6.** Section 1.36B–5 is amended by:

■ 1. Adding a sentence to the end of paragraph (c)(3)(i).

■ 2. Adding paragraphs (c)(3)(iii) and (h).

The additions read as follows:

§ 1.36B–5 Information reporting by Exchanges.

* * * * *

(c) * * *

(3) * * *

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

* * * * *

(iii) *Partial month of coverage.*—(A) *In general.* Except as provided in paragraph (c)(3)(iii)(B) of this section, if an individual is enrolled in a qualified health plan after the first day of a month, the amount reported for that month under paragraphs (c)(1)(iv), (c)(1)(v), and (c)(1)(viii) of this section is \$0.

(B) *Certain mid-month enrollments.* For information reporting that is due on or after January 1, 2019, if an individual's qualified health plan is terminated before the last day of a month, or if an individual is enrolled in coverage after the first day of a month and the coverage is effective on the date of the individual's birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order, the amount reported under paragraphs (c)(1)(iv) and (c)(1)(v) of this section is the premium for the applicable benchmark plan for a full month of coverage (excluding the premium allocated to benefits in excess of essential health benefits), and the

amount reported under paragraph (c)(1)(viii) of this section is the enrollment premium for the month, reduced by any amounts that were refunded.

* * * * *

(h) *Effective/applicability date.* Except for the last sentence of paragraph (c)(3)(i) of this section and paragraph (c)(3)(iii) of this section, this section applies to taxable years ending after December 31, 2013. The last sentence of paragraph (c)(3)(i) of this section and paragraph (c)(3)(iii) of this section apply to taxable years beginning after December 31, 2018. Paragraph (c)(3) of § 1.36B–5 as contained in 26 CFR part I edition revised as of April 1, 2016, applies to information reporting for taxable years ending after December 31, 2013, and beginning before January 1, 2019.

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

§ 1.5000A–3 Exempt individuals.

* * * * *

(e) * * *

(3) * * *

(ii) * * *

(G) *Opt-out arrangements.* [Reserved]

* * * * *

■ **Par. 8.** Section 1.6011–8 is revised to read as follows:

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

(a) *Requirement of return.* Except as otherwise provided in this paragraph (a), a taxpayer who receives the benefit of advance payments of the premium tax credit under section 36B must file an income tax return for that taxable year on or before the due date for the return (including extensions of time for filing) and reconcile the advance credit payments. However, if advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attests to the Exchange to the intention to claim a personal exemption deduction for the individual as part of the determination that the taxpayer is eligible for advance credit payments must file a tax return and reconcile the advance credit payments.

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

PART 301—PROCEDURE AND ADMINISTRATION

■ **Par. 9.** The authority citation for part 301 continues to read in part as follows:

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

Section 301.6011–2 also issued under 26 U.S.C. 6011(e). * * *

§ 301.6011–2 [Amended]

■ **Par. 10.** Section 301.6011–2(b)(1) is amended by adding “1095–B, 1095–C” after “1094 series”, and removing “1095 series”.

John Dalrymple,

Deputy Commissioner for Service and Enforcement.

Approved: December 8, 2016.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

[FR Doc. 2016–30037 Filed 12–14–16; 4:15 pm]

BILLING CODE 4830–01–P

DEPARTMENT OF JUSTICE

28 CFR Parts 0 and 44

[CRT Docket No. 130; AG Order No. 3791–2016 No. RIN 1190–AA71]

Standards and Procedures for the Enforcement of the Immigration and Nationality Act

AGENCY: Civil Rights Division, Department of Justice.

ACTION: Final rule.

SUMMARY: This rule revises the Department of Justice's (Department's) regulations implementing a section of the Immigration and Nationality Act (INA) concerning unfair immigration-related employment practices. The revisions conform the regulations to the statutory text as amended, simplify and add definitions of statutory terms, update and clarify the procedures for filing and processing charges of discrimination, ensure effective investigations of unfair immigration-related employment practices, reflect developments in nondiscrimination jurisprudence, reflect changes in existing practices (e.g., electronic filing of charges), reflect the new name of the office within the Department charged with enforcing this statute, and replace outdated references.

DATES: This rule is effective on January 18, 2017.

FOR FURTHER INFORMATION CONTACT: Alberto Ruisanchez, Deputy Special Counsel, Office of Special Counsel for Immigration-Related Unfair Employment Practices, Civil Rights Division, 950 Pennsylvania Avenue