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## DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG-125398-12]

RIN 1545-BL43

Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to the health insurance premium tax credit enacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended by the Medicare and Medicaid Extenders Act of 2010, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, and the Department of Defense and Full-Year Continuing Appropriations Act, 2011. These proposed regulations affect individuals who enroll in qualified health plans through Affordable Insurance Exchanges (Exchanges) and claim the premium tax credit, and Exchanges that make qualified health plans available to individuals and employers. These proposed regulations also provide guidance on determining whether health coverage under an eligible employer-sponsored plan provides minimum value and affect employers that offer health coverage and their employees.

DATES: Written (including electronic) comments and requests for a public hearing must be received by **INSERT DATE 60 DAYS AFTER PUBLICATION OF THIS**

**DOCUMENT IN THE FEDERAL REGISTER]**

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG-125398-12), Room 5203, Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG-125398-12), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC, or sent electronically via the Federal eRulemaking Portal at [www.regulations.gov](http://www.regulations.gov) (IRS REG-125398-12).

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Andrew S. Braden, (202) 622-4960; concerning the submission of comments and/or requests for a public hearing, Oluwafunmilayo Taylor, (202) 622-7180 (not toll-free calls).

**SUPPLEMENTARY INFORMATION:****Background**

Beginning in 2014, under the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act), eligible individuals who purchase coverage under a qualified health plan through an Affordable Insurance Exchange may receive a premium tax credit under section 36B of the Internal Revenue Code (Code). Section 36B was subsequently amended by the Medicare and Medicaid Extenders Act of 2010, Public Law 111-309 (124 Stat. 3285 (2010)); the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Public Law 112-9 (125 Stat. 36

(2011)); and the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112-10 (125 Stat. 38 (2011)).

Notice 2012-31 (2012-20 IRB 910) requested comments on methods for determining whether health coverage under an eligible employer-sponsored plan provides minimum value (MV). Final regulations under section 36B (TD 9590) were published on May 23, 2012 (77 FR 30377). The final regulations requested comments on issues to be addressed in further guidance. The comments have been considered in developing these proposed regulations.

### Minimum Value

Individuals generally may not receive a premium tax credit if they are eligible for affordable coverage under an eligible employer-sponsored plan that provides MV. An applicable large employer (as defined in section 4980H(c)(2)) may be liable for an assessable payment under section 4980H if a full-time employee receives a premium tax credit.

Under section 36B(c)(2)(C)(ii), a plan fails to provide MV if the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of the costs. Section 1302(d)(2)(C) of the Affordable Care Act provides that, in determining the percentage of the total allowed costs of benefits provided under a group health plan, the regulations promulgated by the Secretary of Health and Human Services (HHS) under section 1302(d)(2) apply.

HHS published final regulations under section 1302(d)(2) on February 25, 2013 (78 FR 12834). The HHS regulations at 45 CFR 156.20 define the percentage of the total allowed costs of benefits provided under a group health plan as (1) the anticipated

covered medical spending for essential health benefits (EHB) coverage (as defined in 45 CFR 156.110(a)) paid by a health plan for a standard population, (2) computed in accordance with the plan's cost-sharing, and (3) divided by the total anticipated allowed charges for EHB coverage provided to a standard population. In addition, 45 CFR 156.145(c) provides that the standard population used to compute this percentage for MV (as developed by HHS for this purpose) reflects the population covered by typical self-insured group health plans.

The HHS regulations describe several options for determining MV. Under 45 CFR 156.145(a)(1), plans may use the MV Calculator (available at <http://cciio.cms.gov/resources/regulations/index.html>). Alternatively, 45 CFR 156.145(a)(2) provides that a plan may determine MV through a safe harbor established by HHS and IRS. For plans with nonstandard features that are incompatible with the MV Calculator or a safe harbor, 45 CFR 156.145(a)(3) provides that the plan may determine MV through an actuarial certification from a member of the American Academy of Actuaries after performing an analysis in accordance with generally accepted actuarial principles and methodologies. Finally, 45 CFR 156.145(a)(4) provides that a plan in the small group market satisfies MV if it meets the requirements for any of the levels of metal coverage defined at 45 CFR 156.140(b) (bronze, silver, gold, or platinum).

#### Miscellaneous Provisions Under Section 36B

To be eligible for a premium tax credit, an individual must be an applicable taxpayer. Under section 36B(c)(1), an applicable taxpayer is a taxpayer whose household income for the taxable year is between 100 percent and 400 percent of the

federal poverty line (FPL) for the taxpayer's family size.

Section 36B(b)(1) provides that the premium assistance credit amount is the sum of the premium assistance amounts for all coverage months in the taxable year for individuals in the taxpayer's family. The premium assistance amount for a coverage month is the lesser of (1) the premiums for the month for one or more qualified health plans that cover a taxpayer or family member, or (2) the excess of the adjusted monthly premium for the second lowest cost silver plan (as described in section 1302(d)(1)(B) of the Affordable Care Act (42 U.S.C. 18022(d)(1)(B)) (the benchmark plan) that applies to the taxpayer over 1/12 of the product of the taxpayer's household income and the applicable percentage for the taxable year. The adjusted monthly premium, in general, is the premium an insurer would charge for the plan adjusted only for the ages of the covered individuals.

Under section 36B(c)(2)(A), a coverage month is any month for which the taxpayer or a family member is covered by a qualified health plan enrolled in through an Exchange and the premium is paid by the taxpayer or through an advance credit payment. Section 36B(c)(2) provides that a month is not a coverage month for an individual who is eligible for other minimum essential coverage. If the other coverage is eligible employer-sponsored coverage, however, it is treated as minimum essential coverage only if it is affordable and provides MV. Eligible employer-sponsored coverage is affordable for an employee and related individuals if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage (9.5 percent for taxable years beginning before January 1, 2015) of the taxpayer's household income. The MV requirement is

discussed in the Explanation of Provisions.

Any arrangement under which employees are required, as a condition of employment or otherwise, to be enrolled in an employer-sponsored plan that does not provide minimum value or is unaffordable, and that does not give the employees an effective opportunity to terminate or decline the coverage, raises a variety of issues. Proposed regulations under section 4980H indicate that if an employer maintains such an arrangement it would not be treated as having made an offer of coverage. As a result, an applicable large employer could be subject to an assessable payment under that section. See Proposed §54.4980H-4(b), 78 FR 250 (January 2, 2013). Such an arrangement would also raise additional concerns. For example, it is questionable whether the law permits interference with an individual's ability to apply for a section 36B premium tax credit by seeking to involuntarily impose coverage that does not provide minimum value. (See, for example, the Fair Labor Standards Act, as amended by section 1558 of the Affordable Care Act, 29 U.S.C. 218c(a).) If an employer sought to involuntarily impose on its employees coverage that did not provide minimum value or was unaffordable, the IRS and Treasury, as well as other relevant departments, may treat such arrangements as impermissible interference with an employee's ability to access premium tax credits, as contemplated by the Affordable Care Act.

## **Explanation of Provisions and Summary of Comments**

### 1. Minimum Value

#### a. In general

The proposed regulations refer to the proportion of the total allowed costs of benefits provided to an employee that are paid by the plan as the plan's MV percentage.

The MV percentage is determined by dividing the cost of certain benefits (described in paragraph b.) the plan would pay for a standard population by the total cost of certain benefits for the standard population, including amounts the plan pays and amounts the employee pays through cost-sharing, and then converting the result to a percentage.

b. Health benefits measured in determining MV

Commentators sought clarification of the health benefits considered in determining the share of benefit costs paid by a plan. Some commentators maintained that MV should be based on the plan's share of the cost of coverage for all EHBs, including those a plan does not offer. Other commentators suggested that the MV percentage should be based on the plan's share of the costs of only those categories of EHBs the plan covers.

The proposed regulations do not require employer-sponsored self-insured and insured large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to qualified health plans. The preamble to the HHS regulations (see 78 FR 12833) notes that employer-sponsored group health plans are not required to offer EHBs unless they are health plans offered in the small group market subject to section 2707(a) of the Public Health Service Act. The preamble also states that, under section 1302(d)(2) of the Affordable Care Act, MV is measured based on the provision of EHBs to a standard population and plans may account for any benefits covered by the employer that also are covered in any one of the EHB-benchmark plans. See 45 CFR 156.145(b)(2).

Consistent with 45 CFR 156.145(a)-(c) and the assumptions described in Notice 2012-31, these proposed regulations provide that MV is based on the anticipated

spending for a standard population. The plan's anticipated spending for benefits provided under any particular EHB-benchmark plan for any State counts towards MV.

c. Health reimbursement arrangements, health savings accounts, and wellness program incentives

i. Arrangements that Reduce Cost-Sharing

Some commentators suggested that current year health savings account (HSA) contributions and amounts newly made available under a health reimbursement arrangement (HRA) should be fully counted toward the plan's share of costs included in calculating MV. Some commentators suggested that only HRA contributions that may be used to pay for cost sharing and not HRAs restricted to other uses should be counted in the MV calculation.

Consistent with 45 CFR 156.135(c), the proposed regulations provide that all amounts contributed by an employer for the current plan year to an HSA are taken into account in determining the plan's share of costs for purposes of MV and are treated as amounts available for first dollar coverage. Amounts newly made available under an HRA that is integrated with an eligible employer-sponsored plan for the current plan year count for purposes of MV in the same manner if the amounts may be used only for cost-sharing and may not be used to pay insurance premiums. It is anticipated that regulations will provide that whether an HRA is integrated with an eligible employer-sponsored plan is determined under rules that apply for purposes of section 2711 of the Public Health Service Act (42 U.S.C. 300gg-11). Commentators offered differing opinions about how nondiscriminatory wellness program incentives that may affect an employee's cost sharing should be taken into account for purposes of the MV calculation. Some commentators noted that the rules governing wellness incentives



require that they be available to all similarly situated individuals. These commentators suggested that because eligible individuals have the opportunity to reduce their cost-sharing if they choose, a plan's share of costs should be based on the costs paid by individuals who satisfy the terms of the wellness program. Other commentators expressed concern that, despite the safeguards of the regulations governing wellness incentives, certain individuals inevitably will face barriers to participation and fail to qualify for rewards. These commentators suggested that a plan's share of costs should be determined without assuming that individuals would qualify for the reduced cost-sharing available under a wellness program.

The proposed regulations provide that a plan's share of costs for MV purposes is determined without regard to reduced cost-sharing available under a nondiscriminatory wellness program. However, for nondiscriminatory wellness programs designed to prevent or reduce tobacco use, MV may be calculated assuming that every eligible individual satisfies the terms of the program relating to prevention or reduction of tobacco use. This exception is consistent with other Affordable Care Act provisions (such as the ability to charge higher premiums based on tobacco use) reflecting a policy about individual responsibility regarding tobacco use.

#### ii. Arrangements that Reduce Premiums

Section 36B(c)(2)(C)(i)(II) and the final regulations provide that eligible employer-sponsored coverage is affordable only if an employee's required contribution for self-only coverage does not exceed 9.5 percent of household income. The preamble to the final regulations indicated that rules for determining how HRAs and wellness program

incentives are counted in determining the affordability of eligible employer-sponsored coverage would be provided in later guidance.

Some commentators asserted that an employer's entire annual contribution to an HRA plus prior year contributions should be taken into account in determining affordability. The proposed regulations provide that amounts newly made available under an HRA that is integrated with an eligible employer-sponsored plan for the current plan year are taken into account only in determining affordability if the employee may use the amounts only for premiums or may choose to use the amounts for either premiums or cost-sharing. Treating amounts that may be used either for premiums or cost-sharing only towards affordability prevents double counting the HRA amounts when assessing MV and affordability of eligible employer-sponsored coverage.

It is anticipated that regulations under section 5000A will provide that amounts newly made available under an HRA that is integrated with an eligible employer-sponsored plan for the current plan year are also taken into account for purposes of the affordability exemption under section 5000A(e)(1) if the employee may use the amounts only for premiums or for either premiums or cost-sharing.

The final regulations requested specific comments on the nature of wellness incentives and how they should be treated for determining affordability. Commentators expressed similar views about the treatment of wellness incentives that affect the cost of premiums as about the treatment of wellness incentives that affect cost-sharing.

Like the rule for determining MV, the proposed regulations provide that the affordability of an employer-sponsored plan is determined by assuming that each employee fails to satisfy the requirements of a wellness program, except the

requirements of a nondiscriminatory wellness program related to tobacco use. Thus, the affordability of a plan that charges a higher initial premium for tobacco users will be determined based on the premium that is charged to non-tobacco users, or tobacco users who complete the related wellness program, such as attending smoking cessation classes.

In many circumstances these rules relating to the effect of premium-related wellness program rewards on affordability will have no practical consequences. They matter only when the employer sets the level of the employee's required contribution to self-only premium, and establishes a wellness program that provides for a level of premium discount, in such a manner that the employee's required contribution to premium would exceed 9.5 percent of household income (or wages, under an affordability safe harbor under the section 4980H proposed regulations) but for the potential premium discount under the wellness program. If, for example, the employee's household income was at least \$25,000, and the employee's required contribution for self-only coverage did not exceed \$2,375 (9.5 percent of \$25,000), the coverage would be affordable whether or not a wellness premium discount was taken into account to reduce the \$2,375 required contribution.

It is anticipated that regulations under section 5000A will provide that nondiscriminatory wellness programs that affect premiums will be treated for purposes of the affordability exemption under section 5000A(e)(1) in the same manner as they are treated for purposes of determining affordability under section 36B.

Solely for purposes of applying section 4980H and solely for plan years of an employer's group health plan beginning before January 1, 2015, with respect to an

employee described in the next sentence, an employer will not be subject to an assessable payment under section 4980H(b) with respect to an employee who received a premium tax credit because the offer of coverage was not affordable or did not satisfy MV, if the offer of coverage to the employee under the employer's group health plan would have been affordable or would have satisfied MV based on the total required employee premium and cost-sharing for that group health plan that would have applied to the employee if the employee satisfied the requirements of any wellness program described in the next sentence, including a wellness program with requirements unrelated to tobacco use. The rule in the preceding sentence applies only (1) to the extent of the reward as of **[INSERT DATE of PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**, expressed as either a dollar amount or a fraction of the total required employee contribution to the premium (or the employee cost-sharing, as applicable), (2) under the terms of a wellness program as in effect on **[INSERT DATE of PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**, and (3) with respect to an employee who is in a category of employees eligible under the terms of the wellness program as in effect on **[INSERT DATE of PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]** (regardless of whether the employee was hired before or after that date). Any required employee contribution to premium determined based upon assumed satisfaction of the requirements of a wellness program available under this transition relief may be applied to the use of an affordability safe harbor provided in the proposed regulations under section 4980H.

d. Standard population and utilization

Consistent with 45 CFR 156.145(c), the proposed regulations provide that the

standard population used to determine MV reflects the population covered by self-insured group health plans. HHS has developed the MV standard population and described it through summary statistics (for example, continuance tables). MV continuance tables and an explanation of the MV Calculator methodology and the health claims data HHS has used to develop the continuance tables are available at <http://cciio.cms.gov/resources/regulations/index.html>.

e. Methods for determining minimum value

Notice 2012-31 and 45 CFR 156.145(a) describe several methods for determining MV: the MV Calculator, a safe harbor, actuarial certification, and, for small group market plans, a metal level. Some commentators requested that plans be allowed to choose one of the four methods in determining MV. Other commentators favored requiring employers to use the most precise method for plans that may be close to the 60 percent threshold.

The proposed regulations provide that taxpayers may determine whether a plan provides MV by using the MV Calculator made available by HHS and the IRS. Taxpayers must use the MV Calculator to measure standard plan features (unless a safe harbor applies), but the percentage may be adjusted based on an actuarial analysis of plan features that are outside the parameters of the calculator.

Certain safe harbor plan designs that satisfy MV will be specified in additional guidance under section 36B or 4980H, see §601.601(d). It is anticipated that the guidance will provide that the safe harbors are examples of plan designs that clearly would satisfy the 60 percent threshold if measured using the MV Calculator. The safe harbors are intended to provide an easy way for sponsors of typical employer-

sponsored group health plans to determine whether a plan meets the MV threshold without having to use the MV Calculator.

Plan designs meeting the following specifications are proposed as safe harbors for determining MV if the plans cover all of the benefits included in the MV Calculator: (1) a plan with a \$3,500 integrated medical and drug deductible, 80 percent plan cost-sharing, and a \$6,000 maximum out-of-pocket limit for employee cost-sharing; (2) a plan with a \$4,500 integrated medical and drug deductible, 70 percent plan cost-sharing, a \$6,400 maximum out-of-pocket limit, and a \$500 employer contribution to an HSA; and (3) a plan with a \$3,500 medical deductible, \$0 drug deductible, 60 percent plan medical expense cost-sharing, 75 percent plan drug cost-sharing, a \$6,400 maximum out-of-pocket limit, and drug co-pays of \$10/\$20/\$50 for the first, second and third prescription drug tiers, with 75 percent coinsurance for specialty drugs. Comments are requested on these and other common plan designs that would satisfy MV and should be designated as safe harbors.

Consistent with 45 CFR 156.145(a), the proposed regulations require plans with nonstandard features that cannot determine MV using the MV Calculator or a safe harbor to use the actuarial certification method. The actuary must be a member of the American Academy of Actuaries and must perform the analysis in accordance with generally accepted actuarial principles and methodologies and any additional standards that subsequent guidance requires.

f. Other issues

Commentators suggested a de minimis exception to the MV 60 percent level of coverage, noting that similar de minimis variations are permitted in determining actuarial

value for qualified health plans. However, as other commentators noted, permitting a de minimis exception would have the effect of lowering the minimum level of coverage to a percentage below 60 percent. Under section 36B(c)(2)(C)(ii), coverage below 60 percent does not provide MV. Accordingly, the proposed regulations do not provide for a de minimis exception.

## 2. Miscellaneous Issues Under Section 36B

### a. Definition of modified adjusted gross income

Section 36B(d)(2) provides that the term household income means the modified adjusted gross income of the taxpayer plus the modified adjusted gross income of all members of the taxpayer's family required to file a tax return under section 1 for the taxable year. The final regulations provide that the determination of whether a family member is required to file a return is made without regard to section 1(g)(7). Under section 1(g)(7), a parent may, if certain requirements are met, elect to include in the parent's gross income, the gross income of his or her child. If the parent makes the election, the child is treated as having no gross income for the taxable year.

The proposed regulations remove "without regard to section 1(g)(7)" from the final regulations because that language implies that the child's gross income is included in both the parent's adjusted gross income and the child's adjusted gross income in determining household income. Thus, the proposed regulations clarify that if a parent makes an election under section 1(g)(7), household income includes the child's gross income included on the parent's return and the child is treated as having no gross income.

### b. Rating area

Section 36B(b)(3)(B) determines the applicable benchmark plan by reference to the rating area where a taxpayer resides. The final regulations reserved the definition of rating area. The proposed regulations provide that the term rating area has the same meaning as used in section 2701(a)(2) of the Public Health Service Act (42 U.S.C. 300gg) and 45 CFR 156.255.

c. Retiree coverage

The section 36B final regulations provide that an individual who may enroll in continuation coverage required under Federal law or a State law that provides comparable continuation coverage is eligible for minimum essential coverage only for months that the individual is enrolled in the coverage. These proposed regulations apply this rule to former employees only. Active employees eligible for continuation coverage as a result of reduced hours should be subject to the same rules for eligibility of affordable employer-sponsored coverage offering MV as other active employees. The proposed regulations add a comparable rule for health coverage offered to retired employees (retiree coverage). Accordingly, an individual who may enroll in retiree coverage is eligible for minimum essential coverage under the coverage only for the months the individual is enrolled in the coverage.

d. Coverage month for newborns and new adoptees

Under section 36B(c)(2)(A)(i) and the final regulations, a month is a coverage month for an individual only if, as of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange. A child born or adopted during the month is not enrolled in coverage on the first day and therefore would not be eligible for the premium tax credit or cost-sharing reductions for that month. Accordingly, the



proposed regulations provide that a child enrolled in a qualified health plan in the month of the child's birth, adoption, or placement with the taxpayer for adoption or in foster care, is treated as enrolled as of the first day of the month.

e. Adjusted monthly premium for family members enrolled for less than a full month

Under section 36B(c), the premium assistance amount for a coverage month is computed by reference to the adjusted monthly premium for an applicable benchmark plan. The final regulations provide that the applicable benchmark plan is the plan that applies to a taxpayer's coverage family. The final regulations do not address whether changes to a coverage family, for example as the result of the birth and enrollment of a child or the disenrollment of another family member, that occur during the month affect the premium assistance amount. The proposed regulations provide that the adjusted monthly premium is determined as if all members of the coverage family for that month were enrolled in a qualified health plan for the entire month.

f. Premium assistance amount for partial months of coverage

The final regulations do not address the computation of the premium assistance amount if coverage under a qualified health plan is terminated during the month. The proposed regulations provide that when coverage under a qualified health plan is terminated before the last day of a month and, as a result, the issuer reduces or refunds a portion of the monthly premium the premium assistance amount for the month is prorated based on the number of days of coverage in the month.

g. Family members residing at different locations.

The final regulations reserved rules on determining the premium for the applicable benchmark plan if family members are geographically separated and enroll in

separate qualified health plans. The proposed regulations provide that the premium for the applicable benchmark plan in this situation is the sum of the premiums for the applicable benchmark plans for each group of family members residing in a different State.

h. Correction to applicable percentage table

The applicable percentage table in the final regulations erroneously states that the 9.5 percentage applies only to taxpayers whose household income is less than 400 percent of the FPL. The proposed regulations clarify that the 9.5 percentage applies to taxpayers whose household income is not more than 400 percent of the FPL.

i. Additional benefits and applicable benchmark plan

Under section 36B(b)(3)(D) and the final regulations, only the portion of the premium for a qualified health plan properly allocable to EHBs determines a taxpayer's premium assistance amount. Premiums allocable to benefits other than EHBs (additional benefits) are disregarded. The final regulations do not address, however, whether a taxpayer's benchmark plan is determined before or after premiums have been allocated to additional benefits. The proposed regulations provide that premiums are allocated to additional benefits before determining the applicable benchmark plan. Thus, only essential health benefits are considered in determining the applicable benchmark plan, consistent with the requirement in section 36B(b)(3)(D) that only essential health benefits are considered in determining the premium assistance amount. In addition, allocating premium to benefits that exceed EHBs before determining the applicable benchmark plan results in a more accurate determination of the premium assistance amount.

j. Requirement to file a return to reconcile advance credit payments

The final regulations provided that a taxpayer who receives advance credit payments must file an income tax return for that taxable year on or before the fifteenth day of the fourth month following the close of the taxable year. Under the proposed regulations, a taxpayer who receives advance credit payments must file an income tax return on or before the due date for the return (including extensions).

**Effective/Applicability Date**

These regulations are proposed to apply for taxable years ending after December 31, 2013. Taxpayers may apply the proposed regulations for taxable years ending before January 1, 2015.

**Special Analyses**

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations and, because the regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

**Comments and Requests for Public Hearing**

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the IRS as

prescribed in this preamble under the “Addresses” heading. Treasury and the IRS request comments on all aspects of the proposed rules. All comments will be available at [www.regulations.gov](http://www.regulations.gov) or upon request. A public hearing will be scheduled if requested in writing by any person who timely submits written comments. If a public hearing is scheduled, notice of the date, time and place for the hearing will be published in the **Federal Register**.

### **Drafting Information**

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

### **Proposed Amendments to the Regulations**

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

#### **PART 1--INCOME TAXES**

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

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

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

1. Revising the introductory text.
2. Adding new entries for §§1.36B-2(c)(3)(iv) and (c)(3)(v)(A)(5) and 1.36B-3(c)(2) and (3), and (d)(1), (2), and (3).
3. Revising the entries for §§1.36B-2(c)(3)(v)(A)(4) and 1.36B-3(c)(4).
4. Adding new entries for §1.36B-6.

The revisions and additions read as follows.

§1.36B-0 Table of contents.

This section lists the captions contained in §§1.36B-1 through 1.36B-6.  
\* \* \* \* \*

§1.36B-2 Eligibility for premium tax credit.

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(iv) Post-employment coverage.

(v) \* \* \*

(A) \* \* \*

(4) Wellness incentives.

(5) Employer contributions to health reimbursement arrangements.

\* \* \* \* \*

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

\* \* \* \* \*

(c) \* \* \*

(2) Child born or adopted during a month.

(3) Premiums paid for a taxpayer.

(4) Examples.

(d) \* \* \*

(1) In general.

(2) Mid-month termination of coverage.

(3) Example.

\* \* \* \* \*

§1.36B-6 Minimum value.

(a) In general.

(b) MV standard population.

(c) MV percentage.

(1) In general.

(2) Wellness incentives.

(i) In general.

(ii) Example.

(3) Health savings accounts.

(4) Health reimbursement arrangements.

(5) Expected spending adjustments for health savings accounts and health reimbursement arrangements.

(d) Methods for determining MV.

(e) Scope of essential health benefits and adjustment for benefits not included in MV Calculator.

- (f) Actuarial certification.
- (1) In general.
- (2) Membership in American Academy of Actuaries.
- (3) Actuarial analysis.
- (4) Use of MV Calculator.
- (g) Effective/applicability date.

Par. 3. Section 1.36B-1 is amended by revising paragraph (e)(1)(ii)(B) and adding paragraph (n) to read as follows:

§1.36B-1 Premium tax credit definitions.

\* \* \* \* \*

(e) \* \* \*

(1) \* \* \*

(ii) \* \* \*

(B) Are required to file a return of tax imposed by section 1 for the taxable year.

\* \* \* \* \*

(n) Rating area. The term rating area has the same meaning as used in section 2701(a)(2) of the Public Health Service Act (42 U.S.C. 300gg(a)(2)) and 45 CFR 156.255.

\* \* \* \* \*

Par. 4. Section 1.36B-2 is amended by:

- 1. Revising paragraphs (c)(3)(iv), (c)(3)(v)(A)(4), and (c)(3)(vi).
- 2. Adding paragraphs (c)(3)(v)(A)(5) and (c)(3)(v)(D), Example 9.

The revisions and additions read as follows:

§1.36B-2 Eligibility for premium tax credit.

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(iv) Post-employment coverage. A former employee who may enroll in continuation coverage required under Federal law or a State law that provides comparable continuation coverage, and an individual who may enroll in retiree coverage under an eligible employer-sponsored plan, are eligible for minimum essential coverage under this coverage only for months that the individual is enrolled in the coverage.

\* \* \* \* \*

(v) \* \* \*

(A) \* \* \*

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

(5) Employer contributions to health reimbursement arrangements. Amounts newly made available for the current plan year under a health reimbursement arrangement that is integrated with an eligible employer-sponsored plan and that an employee may use to pay premiums are counted toward the employee's required contribution.

\* \* \* \* \*

(D) \* \* \*

Example 9. Wellness incentives. (i) Employer X offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by

\$300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by \$200 if an employee completes cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and the cost of his premiums is \$3,700. Employee C uses tobacco and the cost of her premiums is \$4,000.

(ii) Under paragraph (c)(3)(v)(A)(4) of this section, only the incentives related to tobacco use are counted toward the premium amount used to determine the affordability of X's plan. C is treated as having earned the \$300 incentive for attending a smoking cessation course. Thus, the employee's required contribution to premium for determining affordability for both Employees B and C is \$3,700. The \$200 incentive for completing cholesterol screening is disregarded.

(vi) Minimum value. See § 1.36B-6 for rules for determining whether an eligible employer-sponsored plan provides minimum value.

\* \* \* \* \*

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

1. Redesignating paragraphs (c)(2) and (c)(3) as paragraphs (c)(3) and (c)(4) and adding a new paragraph (c)(2).
2. Revising paragraphs (d), (g)(2), (j)(1), and (j)(3).
3. Adding a sentence to the end of paragraph (e).
4. Adding paragraph (f)(4).

The revisions and additions read as follows:

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

\* \* \* \* \*

(c) \* \* \*

(2) Child born or adopted during a month. A child enrolled in a qualified health plan in the month of the child's birth, adoption, or placement with the taxpayer for adoption or in foster care, is treated as enrolled as of the first day of the month for purposes of this paragraph (c).



\* \* \* \* \*

(d) Premium assistance amount--(1) In general. Except as provided in paragraph (d)(2) of this section, the premium assistance amount for a coverage month is the lesser of--

(i) The premiums for the month for one or more qualified health plans in which a taxpayer or a member of the taxpayer's family enrolls; or

(ii) The excess of the adjusted monthly premium for the applicable benchmark plan over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year.

(2) Mid-month termination of coverage. If a qualified health plan is terminated before the last day of a month and, as a result, the issuer reduces or refunds a portion of the monthly premium, the premium assistance amount for the coverage month is the amount that would apply under paragraph (d)(1) of this section for the entire month multiplied by a fraction, the numerator of which is the number of days of enrollment in the month and the denominator of which is the number of days in the month.

(3) Example. The following example illustrates the provisions of this paragraph (d):

Example. (i) Taxpayer R is single and has no dependents. R enrolls in a qualified health plan for 2014 with a monthly premium of \$450. The adjusted monthly premium for R's applicable benchmark plan is \$490 and 1/12 of the product of R's household income and applicable percentage for 2014 (R's contribution amount) is \$190. R takes a new job in September of 2014, enrolls in the employer-sponsored plan, and terminates his enrollment in the qualified health plan, effective on September 10, 2014. The issuer of R's qualified health plan refunds 2/3 of the September premium for R's coverage.

(ii) Under paragraph (d)(1) of this section, R's premium assistance amount for the months January – August of 2014 is \$300, the lesser of \$450 (the monthly premium for the plan in which R enrolls) and \$300 (the excess of the adjusted monthly premium for

R's applicable benchmark plan (\$490) over R's contribution amount (\$190)). Under paragraph (d)(2) of this section, R's premium assistance amount for September is \$100, the premium assistance amount for September had R been enrolled for the full month (\$300), times 10/30 (the number of days R is enrolled in September, over the number of days in September).

(e) \* \* \* The adjusted monthly premium is determined as if all members of the coverage family for that month were enrolled in the qualified health plan for the entire month.

(f) \* \* \*

(4) Family members residing at different locations. The premium for the applicable benchmark plan determined under paragraphs (f)(1) and (f)(2) of this section for family members who live in different States and enroll in separate qualified health plans is the sum of the premiums for the applicable benchmark plans for each group of family members living in the same State.

\* \* \* \* \*

(g) \* \* \*

(2) Applicable percentage table.

Household income percentage of Federal poverty line	Initial percentage	Final percentage
Less than 133%	2.0%	2.0%
At least 133% but less than 150%	3.0%	4.0%
At least 150% but less than 200%	4.0%	6.3%
At least 200% but less than 250%	6.3%	8.05%
At least 250% but less than 300%	8.05%	9.5%
At least 300% but not more than 400%	9.5%	9.5%

\* \* \* \* \*

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

\* \* \* \* \*

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

Example 1. (i) Taxpayer B enrolls in a qualified health plan that provides benefits in addition to essential health benefits (additional benefits). The monthly premium for the plan in which B enrolls is \$370, of which \$35 is allocable to additional benefits. The premium for B's applicable benchmark plan (determined after allocating premiums to additional benefits for all silver level plans) is \$440, of which \$40 is allocable to additional benefits. B's contribution amount, which is the product of B's household income and the applicable percentage, is \$60.

(ii) Under this paragraph (j), the premium for the qualified health plan in which B enrolls and the applicable benchmark premium are reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, the premium for the qualified health plan in which B enrolls is reduced to \$335 (\$370 - \$35) and the premium for B's applicable benchmark plan is reduced to \$400 (\$440 - \$40). B's premium assistance amount for a coverage month is \$335, the lesser of \$335 (the premium for the qualified health plan in which B enrolls, reduced by the portion of the premium allocable to additional benefits) and \$340 (the premium for B's applicable benchmark plan, reduced by the portion of the premium allocable to additional benefits (\$400), minus B's \$60 contribution amount).

Example 2. The facts are the same as in Example 1, except that the plan in which B enrolls provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under paragraph (j) of this section, the premium for B's applicable benchmark plan (\$440) is reduced by the portion of the premium allocable to additional benefits provided under that plan (\$40). The premium for the

plan in which B's enrolls (\$370) is not reduced under this paragraph (j). B's premium assistance amount for a coverage month is \$340, the lesser of \$370 (the premium for the qualified health plan in which B enrolls) and \$340 (the premium for B's applicable benchmark plan, reduced by the portion of the premium allocable to additional benefits (\$400), minus B's \$60 contribution amount).

\* \* \* \* \*

Par. 6. Section 1.36B-6 is added to read as follows:

§1.36B-6 Minimum value.

(a) In general. An eligible employer-sponsored plan provides minimum value (MV) only if the plan's share of the total allowed costs of benefits provided to an employee (the MV percentage) is at least 60 percent.

(b) MV standard population. The MV standard population is a standard population developed and described through summary statistics by the Department of Health and Human Services (HHS). The MV standard population is based on the population covered by typical self-insured group health plans.

(c) MV percentage--(1) In general. An eligible employer-sponsored plan's MV percentage is--

(i) The plan's anticipated covered medical spending for benefits provided under a particular essential health benefits (EHB) benchmark plan described in 45 CFR 156.110 (EHB coverage) for the MV standard population based on the plan's cost-sharing provisions;

(ii) Divided by the total anticipated allowed charges for EHB coverage provided to the MV standard population; and

(iii) Expressed as a percentage.

(2) Wellness incentives--(i) In general. Nondiscriminatory wellness program

incentives offered by an eligible employer-sponsored plan that affect deductibles, copayments, or other cost-sharing are treated as earned in determining the plan's MV percentage to the extent the incentives relate to tobacco use. These wellness program incentives that do not relate to tobacco use are treated as not earned.

(ii) Example. The following example illustrates the rules of this paragraph (c)(2):

Example. (i) Employer X offers an eligible employer-sponsored plan that reduces the deductible by \$300 for employees who do not use tobacco products or who complete a smoking cessation course. The deductible is reduced by \$200 if an employee completes cholesterol screening within the first six months of the plan year. . Employee B does not use tobacco and his deductible is \$3,700. Employee C uses tobacco and her deductible is \$4,000.

(ii) Under paragraph (c)(2)(i) of this section, only the incentives related to tobacco use are considered in determining the plan's MV percentage. C is treated as having earned the \$300 incentive for attending a smoking cessation course. Thus, the deductible for determining for the MV percentage for both Employees B and C is \$3,700. The \$200 incentive for completing cholesterol screening is disregarded.

(3) Health savings accounts. Employer contributions for the current plan year to health savings accounts that are offered with an eligible employer-sponsored plan are taken into account for that plan year towards the plan's MV percentage.

(4) Health reimbursement arrangements. Amounts newly made available for the current plan year under a health reimbursement arrangement that is integrated with an eligible employer-sponsored plan are taken into account for that plan year towards the plan's MV percentage if the amounts may be used only to reduce cost-sharing for covered medical expenses.

(5) Expected spending adjustments for health savings accounts and health reimbursement arrangements. The amount taken into account under paragraph (c)(3) or (c)(4) of this section is the amount of expected spending for health care costs in a benefit year.

(d) Methods for determining MV. An eligible employer-sponsored plan may use one of the following methods to determine whether the plan provides MV--

(1) The MV Calculator made available by HHS and IRS, with adjustments permitted by paragraph (e) of this section;

(2) One of the safe harbors established by HHS and IRS and described in published guidance, see §601.601(d) of this chapter;

(3) Actuarial certification, as described in paragraph (f) of this section, if an eligible employer-sponsored plan has nonstandard features that are not compatible with the MV Calculator and may materially affect the MV percentage; or

(4) For plans in the small group market, conformance with the requirements for a level of metal coverage defined at 45 CFR 156.140(b) (bronze, silver, gold, or platinum).

(e) Scope of essential health benefits and adjustment for benefits not included in MV Calculator. An eligible employer-sponsored plan may include in calculating its MV percentage all benefits included in any EHB benchmark (as defined in 45 CFR part 156). An MV percentage that is calculated using the MV Calculator may be adjusted based on an actuarial analysis that complies with the requirements of paragraph (f) of this section to the extent of the value of these benefits that are outside the parameters of the MV Calculator.

(f) Actuarial certification--(1) In general. An actuarial certification under paragraph (d)(3) of this section must satisfy the requirements of this paragraph (f).

(2) Membership in American Academy of Actuaries. The actuary must be a member of the American Academy of Actuaries.

(3) Actuarial analysis. The actuary's analysis must be performed in accordance

with generally accepted actuarial principles and methodologies and specific standards that may be provided in published guidance, see §601.601(d) of this chapter.

(4) Use of MV Calculator. The actuary must use the MV Calculator to determine the plan's MV percentage for coverage the plan provides that is measurable by the MV Calculator. The actuary may perform an actuarial analysis of the plan's EHB coverage for the MV standard population for benefits not measured by the MV Calculator to determine the effect of nonstandard features that are not compatible with the MV Calculator. The actuary may certify the plan's MV percentage based on the MV percentage that results from use of the MV Calculator and the actuarial analysis of the plan's coverage that is not measured by the MV calculator.

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

Par. 7. Section 1.6011-8 is amended by revising paragraph (a) to read as follows:

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

(a) Requirement of return. A taxpayer who receives advance payments of the premium tax credit under section 36B must file an income tax return for that taxable year on or before the due date for the return (including extensions of time for filing).

\* \* \* \* \*

Steven T. Miller

Deputy Commissioner for Services and Enforcement.