Reg. Section 1.36B-2(c)(5)

Eligibility for premium tax credit

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

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

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

(b) Applicable taxpayer.

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

(2)Married taxpayers must file joint return.

(i) In general. Except as provided in paragraph (b)(2)(ii) of this section, a taxpayer who is married (within the meaning of section 7703) at the close of the taxable year is an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(ii) Victims of domestic abuse and abandonment. Except as provided in paragraph (b)(2)(v) of this section, a married taxpayer satisfies the joint filing requirement of paragraph (b)(2)(i) of this section if the taxpayer files a tax return using a filing status of married filing separately and the taxpayer-

(A) Is living apart from the taxpayer's spouse at the time the taxpayer files the tax return;

(B) Is unable to file a joint return because the taxpayer is a victim of domestic abuse, as described in paragraph (b)(2)(iii) of this section, or spousal abandonment, as described in paragraph (b)(2)(iv) of this section; and

(C) Certifies on the return, in accordance with the relevant instructions, that the taxpayer meets the criteria of this paragraph (b)(2)(ii).

(iii) Domestic abuse. For purposes of paragraph (b)(2)(ii) of this section, domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's

ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.

(iv) Abandonment. For purposes of paragraph (b)(2)(ii) of this section, a taxpayer is a victim of spousal abandonment for a taxable year if, taking into account all facts and circumstances, the taxpayer is unable to locate his or her spouse after reasonable diligence.

(v) Three-year rule. Paragraph (b)(2)(ii) of this section does not apply if the taxpayer met the requirements of paragraph (b)(2)(ii) of this section for each of the three preceding taxable years.

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

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

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

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

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

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

(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.

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

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

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

(c)Minimum essential coverage.

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

(2)Government-sponsored minimum essential coverage.

(i) In general. An individual is eligible for government-sponsored minimum essential coverage if the individual meets the criteria for coverage under a government-sponsored program described in section 5000A(f)(1)(A) as of the first day of the first full month the individual may receive benefits under the program, subject to the limitation in paragraph (c)(2)(ii) of this section. The Commissioner may define eligibility for specific government-sponsored programs further in additional published guidance, see §601.601(d)(2) of this chapter.

(ii) Obligation to complete administrative requirements to obtain coverage. An individual who meets the criteria for eligibility for government-sponsored minimum essential coverage must complete the requirements necessary to receive benefits. An individual who fails by the last day of the third full calendar month

following the event that establishes eligibility under paragraph (c)(2)(i) of this section to complete the requirements to obtain government-sponsored minimum essential coverage (other than a veteran's health care program) is treated as eligible for government-sponsored minimum essential coverage as of the first day of the fourth calendar month following the event that establishes eligibility.

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

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

(v) Determination of Medicaid or Children's Health Insurance Program (CHIP) ineligibility. An individual is treated as not eligible for Medicaid, CHIP, or a similar program for a period of coverage under a qualified health plan if, when the individual enrolls in the qualified health plan, an Exchange determines or considers (within the meaning of 45 CFR 155.302(b)) the individual to be not eligible for Medicaid or CHIP. 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.

(vi) Examples. The following examples illustrate the provisions of this paragraph (c)(2):
Example (1). Delay in coverage effectiveness. On April 10, 2015, Taxpayer D applies for coverage under a government-sponsored health care program. D's application is approved on July 12, 2015, but her coverage is not effective until September 1, 2015. Under paragraph (c)(2)(i) of this section, D is eligible for government-sponsored minimum essential coverage on September 1, 2015.
Example (2). Time of eligibility. Taxpayer E turns 65 on June 3, 2015, and becomes eligible for Medicare. Under section 5000A(f)(1)(A)(i), Medicare is minimum essential coverage. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare in September, which is the last month of E's initial enrollment period. Thus, E may receive Medicare benefits on December 1, 2015. Because E completed the requirements necessary to receive Medicare benefits by the last day of the third full calendar month after the event that establishes E's eligibility (E turning 65), under paragraph (c)(2)(i) and (c)(2)(ii) of this section E

is eligible for government-sponsored minimum essential coverage on December 1, 2015, the first day of the first full month that E may receive benefits under the program.

Example (3). Time of eligibility, individual fails to complete necessary requirements. The facts are the same as in Example 2, except that E fails to enroll in the Medicare coverage during E's initial enrollment period. E is treated as eligible for government-sponsored minimum essential coverage under paragraph (c)(2)(ii) of this section as of October 1, 2015, the first day of the fourth month following the event that establishes E's eligibility (E turning 65).

Example (4). Retroactive effect of eligibility. In November 2014, Taxpayer F enrolls in a qualified health plan for 2015 and receives advance credit payments. F loses her part-time employment and on April 10, 2015 applies for coverage under the Medicaid program. F's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (c)(2)(iv) of this section, F is eligible for government-sponsored minimum essential coverage on June 1, 2015, the first day of the first calendar month after approval.

Example (5). Determination of Medicaid ineligibility. In November 2014, Taxpayer G applies through the Exchange to enroll in health coverage for 2015. The Exchange determines that G is not eligible for Medicaid and estimates that G's household income will be 140 percent of the Federal poverty line for G's family size for purposes of determining advance credit payments. G enrolls in a qualified health plan and begins receiving advance credit payments. G experiences a reduction in household income during the year and his household income for 2015 is 130 percent of the Federal poverty line (within the Medicaid income threshold). However, under paragraph (c)(2)(v) of this section, G is treated as not eligible for Medicaid for 2015.

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

(3)Employer-sponsored minimum essential coverage.

(i)

(A) Plans other than health reimbursement arrangements (HRAs) or other account-based group health plans described in paragraph (c)(3)(i)(B) of this section. 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.

(B) HRAs and other account-based group health plans integrated with individual health insurance coverage. An employee who is offered an HRA or other account-based group health plan that would be integrated with individual health insurance coverage (or Medicare Part A and B or Medicare Part C), within the meaning of Sec. §54.9802-4 and 54.9815-2711(d)(4) of this chapter, if the employee enrolls in individual health insurance coverage (or Medicare Part A and B or Medicare Part C), and an individual who is offered the HRA or other account-based group health plan because of a relationship to the employee (a related HRA individual), are eligible for minimum essential coverage under an eligible employer-sponsored plan for any month for which the HRA or other account-based group health plan is offered if the HRA or other account-based group health plan is affordable for the month under paragraph (c)(5) of this section or if the employee does not opt out of and waive future reimbursements from the HRA or other account-based group health plan. An HRA or other account-based group health plan described in this paragraph (c)(3)(i)(B) that is affordable for a month under paragraph (c)(5) of this section is treated as providing minimum value for the month. For purposes of paragraphs (c)(3) and (5) of this section, the definitions under §54.9815-2711(d)(6) of this chapter apply.

(ii) Plan year. For purposes of this paragraph (c)(3), a plan year is an eligible employer-sponsored plan's regular 12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period). The plan year for an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is the plan's 12-month coverage period (or the remainder of the 12-month coverage period for a newly eligible individual or an individual who enrolls during a special enrollment period).

(iii) Eligibility for months during a plan year.

(A) Failure to enroll in plan. An employee or related individual may be eligible for minimum essential coverage under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period 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).

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

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

Example.

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

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

(iv) Post-employment coverage. A former employee (including a retiree), or an individual related (within the meaning of paragraph (c)(3)(i) of this section) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under Federal law or a State law that provides comparable continuation coverage is eligible for minimum essential coverage under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(v) Affordable coverage.

(A) In general.

(1) Affordability for employee. Except as provided in paragraph (c)(3)(v)(A)(3) of this section, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)(3)(v)(C) of this section) of the applicable taxpayer's household income for the taxable year. See paragraph (c)(5) of this section for rules for when an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for an employee for a month.

(2) Affordability for related individual. Except as provided in paragraph (c)(3)(v)(A)(3) of this section, an eligible employer-sponsored plan is affordable for a related individual if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage, as described in paragraph (c)(3)(v)(A)(1) of this section. See paragraph (c)(5) of this section for rules for when an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a related HRA individual for a month.

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

determines that the eligible employer-sponsored plan is not affordable for that plan year. This paragraph (c)(3)(v)(A)(3) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information about affordability. 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. See paragraph (c)(5) of this section for an employee safe harbor that applies when an Exchange determines that an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is not affordable for an employee or a related HRA individual for the period of enrollment in a qualified health plan.

(4) Wellness program incentives. Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this section, the term wellness program incentive has the same meaning as the term reward in §54.9802-1(f)(1)(i) of this chapter.

(5) Employer contributions to HRAs integrated with eligible employer-sponsored plans. Amounts newly made available for the current plan year under an HRA that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the HRA would be integrated, within the meaning of §54.9815-2711(d)(2) of this chapter, with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the HRA must be offered by the same employer. Employer contributions to an HRA described in this paragraph (c)(3)(v)(A)(5) reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(6) Employer contributions to cafeteria plans. Amounts made available for the current plan year under a cafeteria plan, within the meaning of section 125, reduce an employee's or a related individual's required contribution if-

(i) The employee may not opt to receive the amount as a taxable benefit;

(ii) The employee may use the amount to pay for minimum essential coverage; and

(iii) The employee may use the amount exclusively to pay for medical care, within the meaning of section 213.

(7) Opt-out arrangements. [Reserved]

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

(C) Required contribution percentage. The required contribution percentage is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under published guidance, see §601.601(d)(2) of this chapter. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

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

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

Example (2). Basic determination of affordability for a related individual. The facts are the same as in Example 1, except that C is married to J and X's plan requires C to contribute $5,300 for coverage for C and J for 2014 (11.3 percent of C's household

income). Because C's required contribution for self-only coverage ($3,450) does not exceed 9.5 percent of household income, under paragraph (c)(3)(v)(A)(2) of this section, X's plan is affordable for C and J, and C and J are eligible for minimum essential coverage for all months in 2014.

Example (3). Determination of unaffordability at enrollment.

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

(ii) Based on D's actual 2014 household income, D's required contribution does not exceed 9.5 percent of household income and X's health plan is affordable for D. However, when D enrolled in a qualified health plan for 2014, the Exchange determined that X's plan was not affordable for D for 2014. Consequently, under paragraph (c)(3)(v)(A)(3) of this section, X's plan is not affordable for D and D is not eligible for minimum essential coverage under X's plan for 2014.

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

Example (5). No affordability information affirmatively provided for annual redetermination.

(i) The facts are the same as in Example 3, except the Exchange redetermines D's eligibility for advance credit payments for 2015. D does not affirmatively provide the Exchange with current information regarding affordability and the Exchange determines that D's coverage is not affordable for 2015 and approves advance credit payments based on information from the previous enrollment period. In 2015, D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

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

Example (6). Determination of unaffordability for part of plan year (part-year period).

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

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

Example (7). Affordability determined for part of a taxable year (part-year period).

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

(ii) Because F is a calendar year taxpayer and Employer X's plan is not a calendar year plan, F must determine the affordability of X's coverage for the part-year period in 2014 (September-December) under paragraph (c)(3)(v)(B) of this section. F determines the affordability of X's plan for the September through December 2014 period by comparing the annual premiums ($1,800) to F's 2014 household income. F's required contribution of $1,800 is 10 percent of F's 2014 household income. Because F's required contribution exceeds 9.5 percent of F's 2014 household income, X's plan is not affordable for F for the part-year period September through December 2014 and F is not eligible for minimum essential coverage under X's plan for that period.

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

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

Example (8). Coverage unaffordable at year end. Taxpayer G is employed by Employer X. In November 2014, the Exchange for G's rating area determines that G is eligible for affordable employer-sponsored coverage for 2015. G nonetheless enrolls in a qualified health plan for 2015 but does not receive advance credit payments. G's 2015 household income is less than expected and G's required contribution for employer-sponsored coverage for 2015 exceeds 9.5 percent of G's actual 2015 household income. Under paragraph (c)(3)(v)(A)(1) of this section, G is not eligible for minimum essential coverage under X's plan for 2015.

Example (9). Wellness program 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 regardless of whether C actually attends the course. Thus, the required contribution for determining affordability for both Employee B and Employee C is $3,700. The $200 incentive for completing cholesterol screening is treated as not earned and does not reduce their required contribution.

(vi) Minimum value. See §1.36B-6 for rules for determining whether an eligible employer-sponsored plan provides minimum value. An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section that is affordable for a month under paragraph (c)(5) of this section is treated as providing minimum value for the month.

(vii) Enrollment in eligible employer-sponsored plan.

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

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

(C) Examples. The following examples illustrate the provisions of this paragraph (c)(3)(vii):
Example (1). Taxpayer H is employed by Employer X in 2014. H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.
Example (2). The facts are the same as in Example 1, except that H terminates plan coverage on June 30, 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage under X's plan for January through June 2014 but is not eligible for minimum essential coverage under X's plan for July through December 2014.
Example (3). The facts are the same as in Example 1, except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (c)(3)(vii)(B) of this section, H is not eligible for minimum essential coverage under X's plan for January 2015.

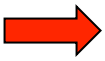
(4)Special eligibility rules.

(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.



(5) or other account-based group health plan.

(i) In general. Except as otherwise provided in this paragraph (c)(5), an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a month if the employee's required HRA contribution (as defined in paragraph (c)(5)(ii) of this section) for the month does not exceed 1/12 of the product of the employee's household income for the taxable year and the required contribution percentage (as defined in paragraph (c)(3)(v)(C) of this section).

(ii) Required HRA contribution. An employee's required HRA contribution is the excess of--

(A) The monthly premium for the lowest cost silver plan for self-only coverage of the employee offered in the Exchange for the rating area in which the employee resides, over

(B) The monthly self-only HRA or other account-based group health plan amount (or the monthly maximum amount available to the employee under the HRA or other account-based group health plan if the HRA or other account-based group health plan provides for reimbursements up to a single dollar amount regardless of whether an employee has self-only or other-than-self-only coverage).

(iii) Monthly amounts.

(A) Monthly lowest cost silver plan premium. For purposes of paragraph (c)(5)(ii)(A) of this section, the premium for the lowest cost silver plan is

determined without regard to any wellness program incentive that affects premiums unless the wellness program incentive relates exclusively to tobacco use, in which case the incentive is treated as earned. If the premium differs for tobacco users and non-tobacco users, the premium for the lowest cost silver plan is the premium that applies to non-tobacco users. For the purpose of this paragraph (c)(5)(iii)(A), the term wellness program incentive has the same meaning as the term reward in 26 CFR 54.9802-1(f)(1)(i). A silver-level qualified health plan that is used for purposes of determining a taxpayer's lowest cost silver plan for self-only coverage under paragraph (c)(5)(ii)(A) of this section does not cease to be the taxpayer's lowest cost silver plan for self-only coverage solely because the plan terminates or closes to enrollment during the taxable year.

(B) Monthly HRA amount. For purposes of paragraph (c)(5)(ii)(B) of this section, the monthly self-only HRA or other account-based group health plan amount is the self-only HRA or other account-based group health plan amount newly made available under the HRA for the plan year, divided by the number of months in the plan year the HRA or other account-based group health plan is available to the employee. The monthly maximum amount available to the employee under the HRA or other account-based group health plan is the maximum amount newly made available for the plan year to the employee under the plan, divided by the number of months in the plan year the HRA or other account-based group health plan is available to the employee.

(iv) Employee safe harbor. An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is not affordable for a month for an employee or a related HRA individual if, when the employee or related HRA individual enrolls in a qualified health plan for a period coinciding with the period the HRA or other account-based group health plan is available to the employee or related HRA individual (in whole or in part), an Exchange determines that the HRA or other account-based group health plan is not affordable for the period of enrollment in the qualified health plan. This paragraph (c)(5)(iv) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information about affordability. This paragraph (c)(5)(iv) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning the relevant HRA or other account-based group health plan amount offered by the employee's employer. 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.

(v) Amounts used for affordability determination. Only amounts that are newly made available for the plan year of the HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section and determinable within a reasonable time before the beginning of the plan year of the HRA or other account-based health plan are considered in determining whether an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable. Amounts made available

for a prior plan year that carry over to the current plan year are not taken into account for purposes of this paragraph (c)(5). Similarly, amounts made available to account for amounts remaining in a different HRA or other account-based group health plan the employer previously provided to the employee and under which the employee is no longer covered are not taken into account for purposes of this paragraph (c)(5).

(vi) Affordability for part-year period. Affordability under this paragraph (c)(5) is determined separately for each employment period that is less than a full calendar year or for the portions of the plan year of an employer's HRA or other account-based group health plan that fall in different taxable years of an applicable taxpayer. An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a part-year period if the employee's annualized required HRA contribution for the part-year period does not exceed the required contribution percentage of the applicable taxpayer's household income for the taxable year. The employee's annualized required HRA contribution is the employee's required HRA contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable taxpayer's taxable year. Only full calendar months are included in the computation under this paragraph (c)(5)(vi).

(vii) Related individual not allowed as a personal exemption deduction. A related HRA individual is treated as ineligible for minimum essential coverage under an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section for months that the employee opted out of and waived future reimbursements from the HRA or other account-based group health plan and the employee is not allowed a personal exemption deduction under section 151 for the related HRA individual.

(viii) Post-employment coverage. An individual who is offered an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section, for months after an employee terminates employment with the employer offering the HRA or other account-based group health plan, is eligible for minimum essential coverage under the HRA or other account-based group health plan for months after termination of employment only if the employee does not forfeit or opt out of and waive future reimbursements from the HRA or other account-based group health plan for months after termination of employment.

(ix) Examples. The following examples illustrate the provisions of this paragraph (c)(5). The required contribution percentage is defined in paragraph (c)(3)(v)(C) of this section and is updated annually. Because the required contribution percentage for 2020 has not yet been determined, the examples assume a required contribution percentage for 2020 of 9.78 percent.
(A)
Example (1). Determination of affordability.
(1) Facts. In 2020 Taxpayer A is single, has no dependents, and has household income of $28,000. A is an employee of Employer X for all of 2020. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses $2,400 of medical care expenses for single employees with no children (the self-only HRA amount) and $4,000 for employees with a spouse or children for the medical expenses of the employees and their family members. A enrolls in a qualified health plan through the

Exchange in the rating area in which A resides and remains enrolled for all of 2020. The monthly premium for the lowest cost silver plan for self-only coverage of A that is offered in the Exchange for the rating area in which A resides is $500.
(2) Conclusion. A's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, is $300, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage of A) over $200 (1/12 of the self-only HRA amount provided by Employer X to its employees). In addition, 1/12 of the product of 9.78 percent and A's household income is $228 ($28,000 x .0978 = $2,738; $2,738/12 = $228). Because A's required HRA contribution of $300 exceeds $228 (1/12 of the product of 9.78 percent and A's household income), the HRA is unaffordable for A for each month of 2020 under paragraph (c)(5) of this section. If A opts out of and waives future reimbursements from the HRA, A is not eligible for minimum essential coverage under the HRA for each month of 2020 under paragraph (c)(3)(i)(B) of this section.

(B)
Example (2). Determination of affordability for a related HRA individual.
(1) Facts. In 2020 Taxpayer B is married and has one child who is a dependent of B for 2020. B has household income of $28,000. B is an employee of Employer X for all of 2020. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses $3,600 of medical care expenses for single employees with no children (the self-only HRA amount) and $5,000 for employees with a spouse or children for the medical expenses of the employees and their family members. B, B's spouse, and B's child enroll in a qualified health plan through the Exchange in the rating area in which B resides and they remain enrolled for all of 2020. No advance credit payments are made for their coverage. The monthly premium for the lowest cost silver plan for self-only coverage of B that is offered in the Exchange for the rating area in which B resides is $500.
(2) Conclusion. B's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, is $200, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage for B) over $300 (1/12 of the self-only HRA amount provided by Employer X to its employees). In addition, 1/12 of the product of 9.78 percent and B's household income for 2020 is $228 ($28,000 x .0978 = $2,738; $2,738/12 = $228). Because B's required HRA contribution of $200 does not exceed $228 (1/12 of the product of 9.78 percent and B's household income for 2020), the HRA is affordable for B under paragraph (c)(5) of this section, and B is eligible for minimum essential coverage under an eligible employer-sponsored plan for each month of 2020 under paragraph (c)(3)(i)(B) of this section. In addition, B's spouse and child are also eligible for minimum essential coverage under an eligible employer-sponsored plan for each month of 2020 under paragraph (c)(3)(i)(B) of this section.

(C)
Example (3). Exchange determines that HRA is unaffordable.
(1) Facts. The facts are the same as in paragraph (c)(5)(ix)(B) of this section (Example 2), except that B, when enrolling in Exchange coverage for B's family, received a determination by the Exchange that the HRA was unaffordable, because B believed B's household income would be lower than it turned out to be. Consequently, advance credit payments were made for their 2020 coverage.
(2) Conclusion. Under paragraph (c)(5)(iv) of this section, the HRA is considered unaffordable for B, B's spouse, and B's child for each month of 2020 provided that B did

not, with intentional or reckless disregard for the facts, provide incorrect information to the Exchange concerning the HRA.

(D)
Example (4). Affordability determined for part of a taxable year (part-year period).
(1) Facts. Taxpayer C is an employee of Employer X. C's household income for 2020 is $28,000. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses medical care expenses of $3,600 for single employees without children (the self-only HRA amount) and $5,000 to employees with a spouse or children for the medical expenses of the employees and their family members. X's HRA plan year is September 1 to August 31 and C is first eligible to participate in the HRA for the period beginning September 1, 2020. C enrolls in a qualified health plan through the Exchange in the rating area in which C resides for all of 2020. The monthly premium for the lowest cost silver plan for self-only coverage of C that is offered in the Exchange for the rating area in which C resides for 2020 is $500.
(2) Conclusion. Under paragraph (c)(3)(vi) of this section, the affordability of the HRA is determined separately for the period September 1 through December 31, 2020, and for the period January 1 through August 31, 2021. C's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, for the period September 1 through December 31, 2020, is $200, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage for C) over $300 (1/12 of the self-only HRA amount provided by X to its employees). In addition, 1/12 of the product of 9.78 percent and C's household income is $228 ($28,000 x .0978 = $2,738; $2,738/12 = $228). Because C's required HRA contribution of $200 does not exceed $228, the HRA is affordable for C for each month in the period September 1 through December 31, 2020, under paragraph (c)(5) of this section. Affordability for the period January 1 through August 31, 2021, is determined using C's 2021 household income and required HRA contribution.

(E)
Example (5). Carryover amounts ignored in determining affordability.
(1) Facts. Taxpayer D is an employee of Employer X for all of 2020 and 2021. D is single. For each of 2020 and 2021, X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that provides reimbursement for medical care expenses of $2,400 to single employees with no children (the self-only HRA amount) and $4,000 to employees with a spouse or children for the medical expenses of the employees and their family members. Under the terms of the HRA, amounts that an employee does not use in a calendar year may be carried over and used in the next calendar year. In 2020, D used only $1,500 of her $2,400 maximum reimbursement and the unused $900 is carried over and may be used by D in 2021.
(2) Conclusion. Under paragraph (c)(5)(v) of this section, only the $2,400 self-only HRA amount offered to D for 2021 is considered in determining whether D's HRA is affordable for D. The $900 carryover amount is not considered in determining the affordability of the HRA.

(d) Applicability date. Paragraphs (b)(2) and (c)(3)(v)(C) of this section apply to taxable years beginning after December 31, 2013.

(e) Effective/applicability date.

(1) Except as provided in paragraphs (e)(2) and (3) 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.

(3) Paragraphs (c)(3)(i)(B) and (c)(5) of this section, and the last sentences of paragraphs (c)(3)(ii), (c)(3)(v)(A)(1) through (3), and (c)(3)(vi) of this section apply to taxable years beginning on or after January 1, 2020.