significant adverse comment, it is withdrawing the direct final rule with this notice. OWCP will address all comments in its final action on the proposed rule. As stated in both the direct final rule and companion proposed rule, OWCP will not institute a second comment period.

Dated: August 20, 2013.

Gary A. Steinberg,

Acting Director, Office of Workers' Compensation Programs.

[FR Doc. 2013–21029 Filed 8–29–13; 8:45 am]

BILLING CODE 4510–CR–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 602

[TD 9632]

RIN 1545–BL36

Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations on the requirement to maintain minimum essential coverage enacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended by the TRICARE Affirmation Act and Public Law 111–173. These final regulations provide guidance to individual taxpayers on the liability under section 5000A of the Internal Revenue Code for the shared responsibility payment for not maintaining minimum essential coverage and largely finalize the rules in the notice of proposed rulemaking published in the **Federal Register** on February 1, 2013.

DATES: *Effective date:* These regulations are effective on August 30, 2013.

Applicability date: For date of applicability, see § 1.5000A–5(c).

FOR FURTHER INFORMATION CONTACT: Sue-Jean Kim or John B. Lovelace at (202) 622–4960 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these regulations has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork and Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545–0074. The collection of information in these final regulations is in § 1.5000A–3 and § 1.5000A–4. The information is necessary to determine whether the shared responsibility payment provision applies to a taxpayer, and, if it applies, the amount of the penalty. The likely respondents are individuals required to file Federal income tax returns under section 6012(a)(1).

Estimated total annual reporting burden: 7,500,000 hours.

Estimated annual burden hours per respondent varies from .1 to .5 hours, depending on individual circumstances, with an estimated average of .21 hours.

Estimated number of respondents: 36,000,000.

Estimated frequency of responses: Annually.

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

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

Background

This document amends the Income Tax Regulations (26 CFR part 1) by adding final regulations under section 5000A on the individual shared responsibility provision. Section 5000A was enacted by the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act). On February 1, 2013, a notice of proposed rulemaking (REG–148500–12) was published in the **Federal Register** (78 FR 7314).

Written comments responding to the notice of proposed rulemaking of February 1, 2013, were received. The comments are available for public inspection at *www.regulations.gov* or on request. A public hearing was held on May 29, 2013. After considering all the comments, the proposed regulations are adopted as revised by this Treasury decision. The comments and revisions are discussed in the preamble.

In related rulemaking, on July 1, 2013, the Department of Health and Human Services (HHS) promulgated final regulations implementing certain functions of the Affordable Insurance Exchanges (Exchanges) to determine eligibility for and grant certain exemptions from the shared responsibility payment under section 5000A, and implementing the responsibilities of the Secretary of HHS, in coordination with the Secretary of the Treasury, to designate other health benefits coverage as minimum essential coverage under section 5000A(f)(1)(E). Patient Protection and Affordable Care Act: Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions, 78 FR 39494 (codified at 45 CFR parts 155 and 156) (the HHS MEC regulations). The HHS MEC regulations provide, among other things, eligibility standards for the hardship exemption, setting forth both general and specific descriptions of the circumstances in which an Exchange will grant a hardship exemption certification as well as those in which a hardship exemption may be claimed on a Federal income tax return. The HHS MEC regulations also designate certain coverage as minimum essential coverage and outline substantive and procedural requirements for other types of coverage to be recognized as minimum essential coverage.

Summary of Comments and Explanation of Revisions

I. Maintenance of Minimum Essential Coverage

A. Coverage for a Month

The proposed regulations provide that, for any calendar month, an individual has minimum essential coverage if the individual is enrolled in and entitled to receive benefits under a program or plan that is minimum essential coverage for at least one day during the month.

A commentator recommended that an individual be covered for a month if the individual is enrolled in and entitled to receive benefits under a plan or program identified as minimum essential coverage for a majority of the days in the month. The commentator asserted that allowing one day of enrollment in a month to satisfy the coverage requirement would permit individuals to obtain minimum essential coverage for only one day and then forgo it for the rest of the month without any adverse consequence under section 5000A.

The Treasury Department and the IRS considered a rule requiring coverage for a majority of days in a month but chose the one-day rule because it provides administrative convenience for both taxpayers and the IRS. Without the one-day rule, taxpayers and the IRS would need to determine the number of days each person in a shared responsibility

family is covered in each month of a taxable year. Accordingly, the final regulations do not adopt this recommendation. The Treasury Department and the IRS will reconsider this rule if future developments indicate that the rule is being abused, for example, if individuals obtain coverage for a single day in a month over the course of several months in a year.

A commentator requested that the final regulations provide that an individual who has submitted an application for Medicaid but is awaiting approval for enrollment have minimum essential coverage while the application is pending approval. In general, Medicaid coverage is granted retroactively to the date the application is filed. Section 5000A(a) requires that an individual have minimum essential coverage for a month. If retroactive coverage is granted, an applicant has minimum essential coverage. If the application is denied, the applicant does not have minimum essential coverage. Accordingly, the final regulations do not adopt this recommendation. However, an individual without coverage may be eligible for an exemption, such as a short coverage gap exemption. See § 1.5000A–3 and 45 CFR 155.605.

B. Liability for Shared Responsibility Payment

1. Liability for Dependents

In general, section 151 allows individual taxpayers a deduction for personal exemptions for the taxpayer, the taxpayer's spouse, and any dependents (as defined in section 152) of the taxpayer for the taxable year. Section 152 defines dependent to include a taxpayer's qualifying children and qualifying relatives. Although a section 151 deduction is allowable to a taxpayer for the taxpayer's dependents (as defined in section 152), a deduction is allowed to a taxpayer under section 151 only if the taxpayer properly claims the dependent. Consistent with section 5000A(b)(3), the proposed regulations provide that a taxpayer is liable for the shared responsibility payment imposed for any individual for a month in a taxable year for which the individual is the taxpayer's dependent (as defined in section 152) for that taxable year. Whether the taxpayer actually claims the individual as a dependent for the taxable year does not affect the taxpayer's liability for the shared responsibility payment for the individual.

Several commentators recommended modifications to the section 5000A rule addressing liability for dependents. Some commentators recommended that a taxpayer's liability for the shared responsibility payment be limited to individuals eligible for the same minimum essential coverage for which the taxpayer is eligible. The commentators stated that many taxpayers are unable to enroll their qualifying children in their employer-provided plans. Other commentators recommended that a taxpayer's liability under section 5000A extend solely to those dependents who meet the requirements to be a qualifying child under section 152, so that a taxpayer's qualifying relatives would be disregarded. In addition, commentators requested that section 5000A liability extend only to those dependents who are actually claimed by the taxpayer. They stated that the complexity in identifying a potential dependent before the taxable year begins, particularly a qualifying relative, would prevent them from making informed coverage decisions. The commentators claimed that, unless the rule is revised, those taxpayers may unexpectedly be liable for shared responsibility payments for dependents for whom a deduction under section 151 is not claimed.

Section 5000A(b)(3) provides that a taxpayer is liable for the shared responsibility payment for an individual without minimum essential coverage if the individual is the taxpayer's dependent as defined in section 152. While the definition of family size in section 5000A(c)(4)(A) refers to dependents for whom a taxpayer claims a deduction under section 151, section 5000A(b)(3) refers to section 152, and section 152 defines dependent based on status as a qualifying child or qualifying relative. Accordingly, the final regulations retain the rule imposing liability on the taxpayer who may claim an individual as a dependent.

Other commentators recommended that a non-custodial parent who must provide the health care of a child under a separation agreement, divorce decree, court order, or other similar legal obligation and who fails to provide that health care be liable for the shared responsibility payment attributable to that child even if the child is the custodial parent's dependent under section 152.

Section 5000A places liability for a dependent's lack of minimum essential coverage on the taxpayer who may claim the individual as a dependent. Section 5000A does not provide that this liability may be assigned to another taxpayer, even if the other taxpayer has a legal obligation to provide the child's health care. Accordingly, the final regulations do not adopt this recommendation. However, HHS has addressed the situation described in the comments in recently issued guidance, permitting Exchanges to grant a hardship exemption under 45 CFR 155.605(g)(1) to the custodial parent for a child in this situation if the child is ineligible for coverage under Medicaid or the Children's Health Insurance Program (CHIP). See HHS Center for Consumer Information & Insurance Oversight, Guidance on Hardship Exemption Criteria and Special Enrollment Periods (June 26, 2013).

2. Special Rule for Adopted Children

The proposed regulations provide special rules for determining liability for the shared responsibility payment attributable to children adopted or placed in foster care during a taxable year. If a taxpayer legally adopts a child and is entitled to claim the child as a dependent for the taxable year when the adoption occurs, the taxpayer is not liable for a shared responsibility payment attributable to the child for the month of the adoption and any preceding month. Conversely, if a taxpayer who is entitled to claim a child as a dependent for the taxable year places the child for adoption during the year, the taxpayer is not liable for a shared responsibility payment attributable to the child for the month of the adoption and any following month.

Similar to the comment on a custodial parent's liability, commentators recommended that a taxpayer's liability for shared responsibility payment for an adopted child be based on the state law assigning responsibility for the child's health care, not when a child is adopted or placed for foster care.

As explained previously in section I.B.1. of this preamble, section 5000A(b)(3) provides that a taxpayer is liable for the shared responsibility payment for an individual without minimum essential coverage if the individual is the taxpayer's dependent as defined in section 152. Determining when a taxpayer is liable for an adopted child's health care under numerous and varying state laws would introduce considerable administrative difficulty and uncertainty into the implementation and administration of section 5000A. Accordingly, the final regulations do not modify the rule for determining liability for the shared responsibility payment attributable to children adopted or placed in foster care during a taxable year.

C. Definitions of Terms

1. Insurance-related Terms

Section 5000A(f)(5) provides that any term used in section 5000A that is also used in Title I of the Affordable Care Act has the same meaning as when used in that Title. To provide additional guidance and clarity, the final regulations specifically identify the terms used in section 5000A that also are used in Title I of the Affordable Care Act. The additional terms defined include health insurance coverage, individual health insurance coverage, individual market, and state.

2. Household Income

Section 5000A(c)(4)(B) 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 proposed 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 final regulations remove ''without regard to section 1(g)(7).'' The proposed regulations' use of the phrase ''without regard to section 1(g)(7)'' 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. The final regulations remove the phrase to 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.

II. Minimum Essential Coverage

A. Government-sponsored Programs

1. Medicaid Coverage for Pregnant Women

The proposed regulations exclude Medicaid coverage for pregnant women under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) (''pregnancy-related Medicaid'') from government-sponsored programs constituting minimum essential coverage. Some commentators commended this treatment of pregnancy-related Medicaid. Other commentators expressed concern that women who have pregnancy-related Medicaid and who do not have any form of minimum essential coverage would, under the proposed regulations, be subject to a shared responsibility payment. The commentators recommended that pregnancy-related Medicaid be considered minimum essential coverage solely for section 5000A (and not section 36B). In the alternative, they recommended that women enrolled in pregnancy-related Medicaid who are not also enrolled in services providing minimum essential coverage be granted a hardship exemption from the shared responsibility payment.

The final regulations do not adopt the recommendation to treat pregnancy-related Medicaid as minimum essential coverage solely for section 5000A. As explained in the preamble to the proposed regulations, states have the option to provide pregnant women with full Medicaid coverage as pregnancy-related Medicaid. Some states adopt this option. Other states do not provide full Medicaid coverage as pregnancy-related Medicaid. The final regulations continue to provide that pregnancy-related Medicaid is not minimum essential coverage.

In addition, the final regulations do not adopt the recommendation that women with pregnancy-related Medicaid be granted a hardship exemption because rules regarding eligibility for the hardship exemption fall under the jurisdiction of HHS. See section 5000A(e)(5).

However, individuals who are eligible for pregnancy-related Medicaid may not know at open enrollment for the 2014 coverage year that such coverage is not minimum essential coverage. Accordingly, the Treasury Department and the IRS anticipate issuing guidance providing that women covered with pregnancy-related Medicaid for a month in 2014 will not be liable for the shared responsibility payment for that month.

2. Section 1115 Demonstration Projects

Section 1115 of the Social Security Act (42 U.S.C. 1315) authorizes the Secretary of HHS to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program (Section 1115 demonstration projects). These projects give states flexibility to test new or existing approaches to financing and delivering Medicaid. Some Section 1115 demonstration projects provide full Medicaid benefits, while others provide a specific and narrow set of benefits similar to the optional coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XXI)) or the optional coverage of tuberculosis-related services under section 1902(a)(10)(A)(ii)(XII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XII)).

The proposed regulations do not specifically address whether Section 1115 demonstration projects constitute Medicaid coverage under Title XIX of the Social Security Act for purposes of section 5000A. A number of commentators recommended against considering as minimum essential coverage Section 1115 demonstration projects that provide a specific and narrow set of benefits.

The final regulations reserve on addressing the status of Section 1115 demonstration projects as minimum essential coverage and, accordingly, do not address the commentators' recommendation that a specific and narrow set of benefits provided under a Section 1115 demonstration project be excluded from the definition of minimum essential coverage. It is anticipated that future regulations that will be effective starting January 1, 2014 will provide that coverage authorized under a Section 1115 demonstration project is not government-sponsored minimum essential coverage. However, certain coverage may be recognized as minimum essential coverage by the Secretary of HHS, in consultation with the Secretary of the Treasury, under section 5000A(f)(1)(E).

Finally, it is anticipated that to the extent future guidance excludes benefits provided under certain Section 1115 demonstration projects from minimum essential coverage, the guidance also will provide that individuals who are enrolled in a Section 1115 demonstration project that is not minimum essential coverage for a month in 2014 will not be liable for the shared responsibility payment for that month.

3. Medicaid Premium Assistance Programs

The proposed regulations do not specifically address whether and to what extent Medicaid premium assistance programs are minimum essential coverage. Commentators recommended that, to preserve affected Medicaid beneficiaries' ability to receive the premium tax credit under section 36B, Medicaid premium assistance programs, which are intended to supplement comprehensive coverage, be excluded from the definition of minimum essential coverage. Commentators referred to, in particular, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) state plan option

(commonly referred to as the ''Katie Beckett option''), coverage under an optional Medicaid coverage group authorized by the Family Opportunity Act of 2006 (FOA), home and community based services waivers, and ''Katie Beckett'' waivers.

Medicaid premium assistance programs function as a service delivery mechanism for benefits covered under the Medicaid program and do not solely supplement a private health insurance plan. In general, Medicaid premium assistance programs are provided under the authority of sections 1905, 1906, and 1906A of the Social Security Act (42 U.S.C. 1396d, 1396e, and 1396e–1) to individuals described in section 1902 of the Social Security Act (42 U.S.C. 1396a) who are eligible for full Medicaid benefits.

Under section 1906 or 1906A of the Social Security Act, states may use Medicaid funds to pay premiums and cost sharing incurred by Medicaid-eligible individuals to enroll in employer-sponsored coverage if it is cost-effective for the state to do so (as compared to the cost of providing covered services through a standard service delivery mechanism, such as fee-for-service or per-patient payments to a managed care organization). States exercising this option must provide ''wrap around'' coverage to ensure individuals can access benefits covered under the state's Medicaid program that are not covered under the employer-sponsored insurance. Authority for states to create similar premium assistance programs for individuals to enroll in private coverage in the individual market is provided in regulations under the authority of section 1905(a)(29) of the Social Security Act published by HHS on July 15, 2013, at 42 CFR 435.1015. Individuals enrolled in the premium assistance programs are eligible for full Medicaid benefits. Accordingly, the final regulations do not adopt the commentators' recommendation. Instead, coverage under a Medicaid premium assistance program under the authority of section 1905, 1906, or 1906A of the Social Security Act to individuals described in section 1902 is minimum essential coverage.

Section 134(a) of TEFRA (Pub. L. 97–248) added section 1902(e)(3) of the Social Security Act (42 U.S.C. 1396a(e)(3)), under which states may provide Medicaid to a disabled child who requires an institutional level of care (such as that provided in a nursing facility) without regard to the income of the child's parent(s). A child eligible under this option is eligible for full Medicaid benefits. Enrollment of the child in private health insurance is not required as a condition of eligibility under the TEFRA option. Whenever a Medicaid beneficiary is enrolled in other coverage, Medicaid serves as the secondary payer. Thus, if a child enrolled in Medicaid under this option also has other coverage, Medicaid will serve as the secondary payer, and in that sense will wrap around the child's private insurance coverage. Because an eligible child receives full Medicaid benefits, the coverage provided is minimum essential coverage.

Sections 6062(a)(1)(A)(iii) and 6062(a)(1)(B) of FOA (Pub. L. 109–171) added sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Social Security Act, under which states may provide Medicaid to disabled children who are not otherwise eligible for Medicaid because their income is too high. Children eligible for Medicaid under this option are entitled to the full Medicaid benefits provided to all other children enrolled in Medicaid. However, under section 1902(cc)(2)(A) of the Social Security Act, if the child's parents have access to employer-sponsored coverage in which the child can enroll and the employer pays at least 50 percent of the annual premium for coverage of the child under the employer plan, the family is required to enroll the child in the employer-sponsored coverage, and Medicaid will wrap around that coverage, providing services not covered under the employer plan. If the parents do not have access to employer-sponsored coverage for the child or if the employer does not contribute at least the minimum amount required, the family is not required to enroll the child in the coverage, and the Medicaid program will cover all Medicaid benefits. In either situation, the child is eligible for all Medicaid benefits. Therefore, coverage under this option is minimum essential coverage.

In addition, under Section 1915(c) of the Social Security Act (42. U.S.C. 1396n(c)) states have the authority to provide home and community based services to certain individuals covered under the Medicaid state plan in addition to the full Medicaid benefit package. Because these individuals receive comprehensive Medicaid benefits, coverage under a home and community based services waiver authorized under section 1915(c) of the Social Security Act is minimum essential coverage.

The treatment of Medicaid coverage provided through a ''Katie Beckett'' waiver referred to by the commentators is addressed in section II.A.2. of this preamble, discussing Section 1115 demonstration projects.

4. Medicaid for the Medically Needy

The Social Security Act provides states with flexibility to extend Medicaid eligibility to individuals with high medical expenses who would otherwise be eligible for Medicaid but for their income level (medically needy individuals). See section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)) and 42 CFR 435.300 and following (Subpart D). Over half of the states have opted to provide coverage to medically needy individuals. In general, individuals whose income is in excess of the maximum allowed for Medicaid eligibility but who are otherwise eligible for Medicaid may ''spend down'' their income, based on incurred medical expenses, and thereby become eligible for the benefits provided for medically needy individuals in the state. States providing coverage to medically needy individuals must establish a ''budget period'' of between one and six months. Eligibility for coverage as a medically needy individual, which must be determined each budget period, is provided only after an individual incurs sufficient medical expenses to ''spend down'' to the qualifying income level. Thus, depending on an individual's medical needs and the options exercised by the state program, eligibility may be assessed as frequently as every month, and an individual may move in and out of Medicaid coverage multiple times in a year. States are permitted, and some have adopted the option, to offer benefits to the medically needy that are more limited than the benefits generally provided to Medicaid beneficiaries.

Commentators requested excluding Medicaid coverage provided to medically needy individuals from the definition of minimum essential coverage because the benefits available may be limited. In addition, treating Medicaid coverage for the medically needy as minimum essential coverage can lead those individuals to experience multiple changes in premium tax credit eligibility throughout a year, creating administrative complexity.

The final regulations reserve on whether Medicaid coverage provided to a medically needy individual is minimum essential coverage. It is anticipated that future regulations that will be effective starting in 2014 will provide that Medicaid coverage provided to a medically needy individual is not government-sponsored minimum essential coverage. However, certain coverage of this type may be recognized as minimum essential coverage by the HHS Secretary, in

consultation with the Treasury Secretary, under section 5000A(f)(1)(E).

To the extent that future guidance excludes certain Medicaid coverage provided to medically needy individuals from the definition of minimum essential coverage, it is anticipated that the guidance also will provide that individuals receiving Medicaid coverage provided to medically needy individuals for a month in 2014 will not be liable for the shared responsibility payment for that month.

5. TRICARE

In accordance with section 5000A(f)(1)(A)(v), the proposed regulations provide that minimum essential coverage under government-sponsored programs includes medical coverage under chapter 55 of Title 10, U.S.C., including coverage under the TRICARE program. However, after publishing the proposed regulations, the Treasury Department and the IRS identified two programs under chapter 55 of Title 10, U.S.C., as providing benefits and services that are limited either in availability or in scope: (1) The program providing care limited to the space available in a facility for the uniformed services for individuals excluded from TRICARE coverage under section 1079(a), 1086(c)(1), or 1086(d)(1) of Title 10, U.S.C.; and (2) the program for individuals not on active duty for an injury, illness, or disease, incurred or aggravated in the line of duty under sections 1074a and 1074b of Title 10, U.S.C.

The proposed regulations exclude certain government-provided health care programs from the definition of minimum essential coverage because they do not provide a comprehensive level of benefits. Similarly, certain limited benefit TRICARE programs do not provide a comprehensive level of benefits. It is anticipated that future regulations that will be effective starting in 2014 will provide that coverage under a limited benefit TRICARE program is not minimum essential coverage. However, the final regulations reserve on the status of these programs as minimum essential coverage.

It is anticipated that if future guidance excludes the limited-availability TRICARE program under section 1079(a), 1086(c)(1), or 1086(d)(1) of Title 10, U.S.C., and the limited-scope line-of-duty TRICARE program under sections 1074a and 1074b of Title 10, U.S.C., from the definition of minimum essential coverage, the guidance also will provide that individuals enrolled in either TRICARE program for any month in 2014 will not be liable for a shared responsibility payment for that month.

B. Eligible Employer-Sponsored Coverage

1. Self-Insured Group Health Plans

The preamble to the proposed regulations explains that a self-insured group health plan is an eligible employer-sponsored plan. Several commentators requested additional clarification concerning the treatment of a self-insured group health plan because these plans are not offered in a large or small group market within a state. The rule in the proposed regulations is revised to clarify that a self-insured group health plan is an eligible employer-sponsored plan, regardless of whether the plan could be offered in the large or small group market in a state.

2. Arrangements To Provide Employer-Subsidized Coverage Under Plans in the Individual Market

The proposed regulations do not specifically address arrangements in which an employer provides subsidies or funds a pre-tax arrangement for employees to use to obtain coverage under plans offered in the individual market (as defined in section 5000A(f)(1)(C)). The Treasury Department and the IRS received several comments on arrangements of this type. One commentator suggested that certain arrangements of this type be treated as eligible employer-sponsored plans, arguing that treating these arrangements as eligible employer-sponsored plans would increase flexibility for employers and employees in satisfying their respective shared responsibility requirements.

The final regulations do not specifically address these arrangements. It is anticipated that future guidance will address the application of section 5000A and the ACA's insurance market reforms to these types of arrangements.

3. Former Employees

The proposed regulations provide that the term *employee* includes former employees and, as a result, treat coverage provided by an employer to former employees as coverage under an eligible employer-sponsored plan. Commentators noted that retiree coverage may be unlike coverage offered to current employees in terms of cost, scope of benefits, and enrollment opportunities and, therefore, should be treated differently from other employer-provided coverage.

Employer-sponsored group health plans offered to former employees are treated similarly for purposes of the Public Health Service Act, the Employee Retirement Income Security Act, and other provisions of the Code. Therefore, the final regulations do not adopt this suggestion, and retiree coverage under a group health plan is minimum essential coverage. However, the final regulations provide that, for the lack of affordable coverage exemption, an individual will not be eligible for retiree coverage unless the individual enrolls. Therefore, an individual who is eligible for retiree coverage but does not enroll disregards that eligibility in determining qualification for the lack of affordable coverage exemption.

4. Plans Offered on Behalf of Employers

The Treasury Department and the IRS received comments asking whether medical coverage offered to employees by an organization acting on behalf of an employer qualifies as an eligible employer-sponsored plan. For example, commentators asked whether a multiemployer plan or a single employer collectively-bargained plan is an eligible employer-sponsored plan for the employees covered by the collective bargaining arrangement and eligible to participate in the plan. In addition, commentators asked whether a plan offered to an employer's employees by a third party, such as a professional employer organization or leasing company, is an eligible employer-sponsored plan for the employees eligible to participate in the plan. The final regulations are revised to provide that a plan offered by an employer to an employee includes a plan offered to an employee on behalf of an employer. No inference is intended from this treatment that the third party is the employer for this or any other provision of the Code or related laws.

5. Government-sponsored Programs That are Eligible Employer-sponsored Plans

The proposed regulations provide that a government-sponsored program (as described in § 1.5000A–2(b)(2) of the proposed regulations) is not an eligible employer-sponsored plan. However, some individuals are eligible for minimum essential coverage under government-sponsored plans by reason of employment with the United States government. For example, 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 (Pub. L. 103–337; 10 U.S.C. 1587 note), is offered by an instrumentality of the Department of Defense to its employees. Accordingly, the final regulations provide that the

Nonappropriated Fund Health Benefits Program is a government-sponsored program and an eligible employer-sponsored plan. The Treasury Department and the IRS are considering whether other government-sponsored programs are eligible employer-sponsored plans.

C. Plan in the Individual Market

The proposed regulations provide that a *plan in the individual market* means health insurance coverage offered to individuals not in connection with a group health plan, including a qualified health plan offered by an Exchange. Commentators stated that this definition is ambiguous about whether qualified health plans are plans in the individual market. The final regulations clarify that qualified health plans offered through Exchanges are plans in the individual market.

Another commentator asked whether a plan offered to one specific individual is a plan in the individual market. A plan offered to one specific individual is a plan in the individual market only if the plan is health insurance coverage under section 2791(b)(1) of the Public Health Service Act, is not short-term limited duration coverage, and is offered in the individual market within a state. The final regulations clarify the meaning of the term plan in the individual market by restating definitions of other essential terms.

D. Foreign Issuer Coverage

1. In General

Under section 5000A(f)(4) and § 1.5000A–1(b)(2) of the final regulations, an individual is treated as having minimum essential coverage for a month if the individual is a bona fide resident of a United States possession for the month, or if the month occurs during any period described in section 911(d)(1)(A) or section 911(d)(1)(B) that is applicable to the individual. Section 911(d)(1)(A) is applicable to a citizen of the United States who has a tax home outside the United States and is a bona fide resident of a foreign country or countries during an uninterrupted period that includes an entire taxable year. Section 911(d)(1)(B) is applicable to a U.S. citizen or U.S. resident (as defined in section 7701(b)) who has a tax home outside the United States and is present in a foreign country or countries for at least 330 full days during a period of 12 consecutive months.

A commentator expressed a concern that a United States citizen or national who resides outside the United States may be subject to the shared responsibility penalty even if the individual has health care coverage provided by a foreign health insurance issuer (sometimes referred to as a form of expatriate coverage) or the government of the foreign country where the individual resides. The commentator requested that individuals in this situation be exempt from section 5000A.

Under section 5000A(f)(4), a United States citizen or national satisfying the requirements of section 911(d)(1) is deemed to have minimum essential coverage. If the individual does not satisfy those requirements, the remaining provisions of section 5000A apply. Accordingly, the final regulations do not adopt the recommendation.

The same commentator and another commentator asked whether expatriate coverage or coverage provided by a foreign insurance issuer to foreign nationals lawfully present in the United States for an extended period of time is minimum essential coverage. The commentators acknowledged that some coverage provided by a foreign health insurance issuer is not offered in the small or large group market, or the individual market, within a state. However, the commentators noted that the foreign health care coverage may be substantially similar to other types of plans recognized as minimum essential coverage.

Under section 1304(d) of the Affordable Care Act (42 U.S.C. 18024(d)) and the final regulations, the term *state* means each of the 50 states and the District of Columbia. Coverage or a plan provided by an issuer that is not offered within a state is neither an eligible employer-sponsored plan nor a plan in the individual market. Accordingly, the final regulations do not adopt this recommendation.

However, to provide relief in the situations that the two commentators described, the HHS MEC regulations provide a process by which a sponsor of a health plan, whether domestic or foreign, may apply for recognition as minimum essential coverage under section 5000A(f)(1)(E). See 45 CFR 156.604.

2. Territory of the United States

A commentator questioned whether coverage offered by issuers located in territories of the United States is minimum essential coverage. Insured plans must be offered within a state to be treated as an eligible employer-sponsored plan or as a plan in the individual market. Section 1304(d) of the Affordable Care Act (42 U.S.C. 18024(d)) and the final regulations provide that the term *state* means each of the 50 states and the District of Columbia. Consequently, in general, health insurance coverage and insured group health plans that are not offered within one of the 50 states or the District of Columbia are neither eligible employer-sponsored plans nor plans in the individual market.

However, section 1323(a)(1) of the Affordable Care Act (42 U.S.C. 18043(a)(1)) provides that a territory electing to establish an Exchange in accordance with part II of subtitle D of the Affordable Care Act is treated as a state for applying basic rules governing qualified health plans offered through Exchanges. As discussed earlier in this preamble, a qualified health plan offered through an Exchange is a plan in the individual market within a state. Accordingly, the final regulations clarify that a qualified health plan offered through an Exchange established by and within a territory of the United States under section 1323(a)(1) of the Affordable Care Act is a plan in the individual market within a state.

III. Exempt Individuals

A. Members of Recognized Religious Sects or Divisions

Consistent with section 5000A(d)(2)(A), the proposed regulations provide that individuals who are members of a recognized religious sect or division of the sect described in section 1402(g)(1) and who are adherents of the established tenets or teachings of the sect or division are eligible to receive a religious conscience exemption certification from an Exchange. Commentators recommended that section 5000A(d)(2)(A) be narrowly construed to limit the ability of parents who qualify for this religious conscience exemption to apply for a religious conscience exemption on behalf of any minor children who, owing to their youth, should not be considered full members of a recognized religious sect or division of the sect.

Section 5000A(d)(2)(A) does not make a distinction between full and less than full membership in a sect or division. Accordingly, the final regulations do not adopt this recommendation. However, as explained in the preamble to the proposed regulations, the section 5000A religious conscience exemption is administered by HHS through Exchanges. The HHS MEC regulations permit adult members of a sect or division to apply for the exemption on behalf of their minor children. *See* 45 CFR 155.600 (definitions of applicant and application filer); 45 CFR 155.605(c)(1) (eligibility standards for religious conscience exemption). Those

regulations further provide, however, that once a child turns 21 years of age, to maintain the religious conscience exemption the child must reapply for the exemption and attest to membership individually. See 45 CFR 155.605(c)(2).

B. Members of Health Care Sharing Ministries

The proposed regulations provide an exemption for members of health care sharing ministries as defined in section 5000A(d)(2)(B)(ii). Commentators recommended that individuals seeking the exemption based on their membership in health care sharing ministries be required to demonstrate membership for every month of the taxable year for which they seek the exemption. The proposed regulations provide that eligibility for the exemption for members of a health care sharing ministry is determined monthly, and the final regulations retain this rule.

C. Exempt Noncitizens

Section 5000A(d)(3) and the proposed regulations provide that an individual who is not a citizen or national of the United States is exempt for a month if the individual is not lawfully present in the United States in that month. The proposed regulations provide that, for this exemption, an individual who is not a citizen or national of the United States is treated as not lawfully present in the United States for a month in a taxable year if the individual is either (1) a nonresident alien as defined in section 7701(b)(1)(B) for that taxable year or (2) does not have lawful immigration status in the United States (within the meaning of 45 CFR 155.20) for any day in the month.

Many commentators requested guidance on how individuals claim the exemption for being not lawfully present in the United States and recommended several reporting methods for this exemption. The final regulations do not adopt any of the recommended reporting methods. However, guidance on claiming exemptions will be provided in forms, instructions, publications, or other guidance published by the IRS, and these comments will be considered in developing that guidance.

Commentators also requested that the exemption for individuals not lawfully present in the United States apply to all members of a taxpayer's family if the taxpayer qualifies for the exemption. Section 5000A applies its coverage requirement and exemptions on an individual basis, which is inconsistent with the commentators' recommendation. Accordingly, the final regulations do not adopt this suggestion.

D. Incarcerated Individuals

Section 5000A(d)(4) provides that an individual is exempt for a month for which the individual is incarcerated (other than incarceration pending the disposition of charges). The proposed regulations clarify that an individual confined for at least one day in a jail, prison, or similar penal institution or correctional facility after the disposition of charges is exempt for the month that includes the day of confinement.

A commentator urged that those incarcerated while awaiting the final disposition of charges also be given an exemption on account of their incarceration. This recommendation is inconsistent with section 5000A(d)(4), which distinguishes between individuals incarcerated while awaiting final disposition of charges and those incarcerated after the final disposition of charges. Accordingly, the final regulations do not adopt this suggestion.

In the alternative, the commentator requested treating incarcerated individuals whose Medicaid benefits have been suspended as having minimum essential coverage. An individual incarcerated pending disposition of charges whose Medicaid benefits have been suspended remains enrolled in Medicaid, is entitled to receive benefits for healthcare provided outside the state prison system, and is not required to re-enroll in Medicaid at the end of incarceration. Thus, treating the individual as covered under Medicaid is consistent with § 1.5000A–1(b)(1), which provides that an individual has minimum essential coverage for the month when the individual is enrolled in and entitled to receive benefits under a program or plan identified as minimum essential coverage in § 1.5000A–2 for at least one day in the month. Accordingly, an individual incarcerated pending disposition of charges whose Medicaid benefits have been suspended is covered under minimum essential coverage, and no revision to the regulations is necessary to address the commentator's concern.

E. Individuals Who Cannot Afford Coverage

1. Household Income

To determine affordability of coverage, section 5000A(e)(1)(A) and the proposed regulations require taxpayers to increase household income by the portion of the required contribution made through a salary reduction arrangement and excluded from gross income. The preamble to the proposed regulations notes that the information necessary to make the required adjustment may not be readily available to the employee or the IRS and requests comments on practicable ways, if any, for making the adjustment.

A commentator stated that the information required is not readily available. The commentator recommended that, considering the limited effect of the required adjustment, the IRS postpone enforcement of the adjustment until a later year when the necessary information may become more readily available and when the effect of the adjustment may be accurately assessed.

The portion of the required contribution made through a salary reduction arrangement that is excluded from gross income includes amounts that an employee pays out of the employee's salary on a pre-tax basis for minimum essential coverage under a cafeteria plan that is an eligible employer-sponsored plan. Although the information may not be readily available, generally it is possible for an employee to identify amounts paid through a salary reduction arrangement that are excluded from the individual's gross income. In addition, under the HHS MEC regulations, a hardship exemption is available for an individual who lacks access to affordable minimum essential coverage based on projected household income. An individual seeking this exemption must adjust projected household income by the amount paid through a salary reduction arrangement for minimum essential coverage that is excluded in the prior year. Accordingly, the final regulations do not adopt this recommendation.

Several commentators suggested allowing an exemption or safe harbor for individuals whose income early in the taxable year appears to entitle them to the lack of affordable coverage exemption and who, as a result, do not obtain minimum essential coverage. If these individuals have large increases in income later in the year, they may be liable for the shared responsibility payment if no other exemption applies. The final regulations do not adopt this recommendation because it is not administrable. The IRS does not have the monthly income data necessary to verify eligibility for the proposed safe harbor or exemption. However, as explained in this preamble, the HHS MEC regulations provide for a prospective hardship exemption based on a lack of affordable coverage determined on the basis of projected household income. Individuals may mitigate potential adverse consequences of mid-year increases in household income by applying for this hardship exemption prospectively.

2. Required Contribution Percentage

One commentator requested a special rule for determining the inflation adjustment of the required contribution percentage for low-income taxpayers to provide relief if health care expenses grow more rapidly than incomes. Section 5000A(e)(1)(D) provides specific rules for annually calculating a uniform required contribution inflation adjustment. Accordingly, the final regulations do not adopt this suggestion.

The commentator also requested a special rule to avoid requiring individuals to visit Exchanges to apply for a hardship exemption. Under section 5000A(e)(5), the authority to prescribe the procedures for applying for exemptions resides with the Secretary of HHS. Based on this authorization, the HHS MEC regulations provide guidance addressing which hardship exemptions must be acquired through an Exchange and which may be claimed directly on a Federal income tax return.

3. Required Contribution

a. In General

A commentator recommended that individuals who are eligible for unaffordable coverage under an eligible employer-sponsored plan qualify for the lack of affordable coverage exemption only if coverage purchased through an Exchange would also be unaffordable. The commentator noted that those individuals might find affordable coverage under plans in the individual market and that, if so, they should be encouraged to enroll in them. Section 5000A(e)(1)(B) defines the required contribution for two discrete groups based on whether an individual is eligible for coverage under eligible employer-sponsored plans. An individual cannot be described in both groups. Thus, section 5000A does not require an individual to test the affordability of coverage under both an eligible employer-sponsored plan and a plan in the individual market. Accordingly, the final regulations do not adopt this suggestion.

b. Required Contribution for Individuals Eligible for Coverage Under Eligible Employer-sponsored Plans

The proposed regulations under section 36B published on May 3, 2013 (78 FR 25909) (the proposed minimum value regulations) provide that amounts newly made available for the current plan year under a health reimbursement arrangement (HRA) that is integrated with an eligible employer-sponsored plan are counted toward the employee's required contribution in determining the affordability of the coverage if the employee may use the amounts only for premiums or may choose to use the amounts for either premiums or cost sharing. The preamble to the proposed minimum value regulations states that regulations under section 5000A will provide a similar rule for determining the effect of amounts newly made available under an HRA for each plan year on the determination of affordability of minimum essential coverage. It is anticipated that future guidance under section 5000A will address the treatment of employer contributions to HRAs in determining the required contribution in a manner consistent with the treatment of these contributions in final rulemaking under section 36B.

The proposed regulations provide that a former employee eligible to enroll in continuation coverage is eligible for coverage under an eligible employer-sponsored plan only if the former employee enrolls in it. In addition to extending this rule to retiree coverage, the final regulations clarify that an individual eligible for continuation or retiree coverage because of a relationship to a former employee is treated in the same manner as the former employee. Therefore, individuals eligible for continuation or retiree coverage who do not enroll in it, and who are not eligible for coverage under another eligible employer-sponsored plan, determine qualification for the lack of affordable coverage exemption under the rules that apply to individuals ineligible for coverage for eligible employer-sponsored plans.

c. Required Contribution for Individuals Ineligible for Coverage Under Eligible Employer-sponsored Plans

To determine the required contribution for individuals who are ineligible for coverage under eligible employer-sponsored plans, the proposed regulations provide that the required contribution is the premium for the applicable plan reduced by the amount of the credit allowable under section 36B. The proposed regulations further provide that, in general, the applicable plan is the lowest cost bronze plan available in the Exchange serving the rating area where the individual resides that would cover all members of the individual's nonexempt family taking into account the rating factors (for example, an individual's age) that an Exchange would use to determine the cost of coverage. The proposed regulations allow taxpayers to make an irrevocable election to use a simplified method to determine the premium for the applicable plan.

One commentator requested that the election to use the simplified method to determine the premium for the applicable plan, when a plan is not offered that covers members of the entire tax household, be revocable. The Treasury Department and the IRS are considering the comment, as well as alternative simplified methods of identifying the premium for the applicable plan. Accordingly, the final regulations remove the simplified method rule that was included in the proposed regulations and reserve on providing simplified methods for identifying the premium for the applicable plan.

A commentator asked that characteristics of individuals in a taxpayer's nonexempt family taken into account in identifying the applicable plan expressly include tobacco use. The rule is intended to reflect as accurately as possible a taxpayer's actual premium amount. Therefore, the final regulations clarify that the characteristics used to identify the applicable plan include tobacco use.

It is anticipated that future HHS guidance will specify that when determining eligibility for the hardship exemption for individuals who lack affordable coverage based on projected income described in 45 CFR 155.605(g)(2), the Exchange will calculate advance payments of the premium tax credit using the rules specified in the regulations under section 36B, providing that individuals who have minimum essential coverage are excluded from the computation of the applicable benchmark plan. This treatment will ensure that Exchanges can reuse existing advance payment functionality instead of having to develop additional functionality for the sole purpose of supporting this exemption.

d. Wellness Program Incentives

The proposed regulations do not address wellness program incentives. Commentators recommended determining an individual's required contribution without regard to any wellness program incentives that, if received, would lower premiums. A commentator asked that premiums for the applicable plan for an individual residing in a rating area in a state participating in the Individual Market Wellness Program Demonstration Project described in section 2705(l) of the Public Health Service Act (42 U.S.C. 300gg–4(l)) disregard any premium-based wellness incentive requirements, including incentives relating to tobacco use. The proposed minimum value regulations disregard wellness program

incentives, except those related to tobacco use, in determining an employee's required contribution under section 36B(c)(2)(C)(i). It is anticipated that future guidance under section 5000A will address the treatment of wellness program incentives in determining the required contribution in a manner consistent with the treatment of these incentives in final rulemaking under section 36B.

F. Household Income Below the Return Filing Threshold

The proposed regulations exempt an individual for a month in a calendar year if the individual's household income for the taxable year is less than the applicable filing threshold. The proposed regulations provide that this below filing threshold exemption may be claimed on an income tax return. Under the proposed regulations an individual is not required to file an income tax return to claim this exemption. One commentator requested that a taxpayer with household income below the applicable filing threshold who files a return remain eligible for this exemption. The final regulations retain the rule that an individual is not required to file a Federal income tax return to claim this exemption and clarify that a taxpayer with household income below the applicable filing threshold who files a Federal income tax return may claim the exemption on the filed return.

The same commentator inquired whether the filing threshold rule for dependents in § 1.5000A–3(f)(2)(ii) of the proposed regulations affects the definition of household income in § 1.5000A–1(d)(7). Under § 1.5000A–3(f)(2)(ii) a dependent's applicable filing threshold is the same as the threshold for the taxpayer claiming the dependent. Section 5000A(e)(2) allows an exemption for an individual whose household income is less than the amount of gross income specified in section 6012(a)(1) *with respect to the taxpayer.* The taxpayer referred to in section 5000A(e)(2) is the taxpayer claiming the dependent. Accordingly, a dependent claimed for an exemption deduction uses the family's household income and the taxpayer's applicable filing threshold in determining eligibility for the below filing threshold exemption. This treatment has no effect on the household income definition.

G. Members of Indian Tribes

The proposed regulations provide an exemption for individuals who are members of federally-recognized Indian tribes. Many commentators were concerned that this exemption was overly restrictive and recommended that the final regulations broaden the exemption to include all individuals who are eligible to receive services through the Indian Health Service, a tribe or tribal organization clinic, or an urban Indian organization (collectively referred to as I/T/U services). Alternatively, commentators asked that coverage under I/T/U services be recognized as minimum essential coverage solely for section 5000A or that these individuals be eligible for a hardship exemption from Exchanges.

The final regulations do not define coverage under I/T/U services as minimum essential coverage because section 5000A does not specifically identify I/T/U services as minimum essential coverage. However, following consultation among HHS, tribal groups, and the Treasury Department and the IRS, the HHS MEC regulations provide a hardship exemption for an individual who is not a member of a federally-recognized Indian tribe, but who is eligible for services through an Indian health care provider, as defined in 42 CFR 447.50, or is eligible for services through Indian Health Service in accordance with 25 U.S.C. 1680c(a), (b), or (d)(3). See 45 CFR 155.605(g)(6).

Several commentators also requested that individuals be allowed to claim the hardship exemption for those eligible for I/T/U services on their income tax returns. The final regulations do not adopt this suggestion because section 5000A(e)(5) provides HHS, through Exchanges, with the authority to grant hardship exemptions not delegated to the IRS.

H. Short Coverage Gap

The proposed regulations provide that an individual qualifies for the short coverage gap exemption if the continuous period without minimum essential coverage is less than three full calendar months and is the first short coverage gap in the individual's taxable year. Further, in determining whether a gap in coverage qualifies as a short coverage gap, the length of the period without minimum essential coverage is measured by reference to calendar months (for example, January or February) in conjunction with the one day rule in § 1.5000A–1(b). Therefore, if an individual is enrolled in and entitled to receive benefits under a plan identified as minimum essential coverage for one day in a calendar month, the month is not included in the continuous period when applying the short coverage gap exemption.

Some commentators recommended making the short coverage gap exemption available to cover an aggregate period of coverage of less than three months, regardless of whether the period was continuous. The commentators noted that those who switched jobs frequently might have numerous short gaps in coverage throughout the year. The commentators' recommendation is inconsistent with section 5000A(e)(4)(B)(iii), which limits the short coverage gap exemption to one continuous period of less than three months. Accordingly, the final regulations do not adopt this suggestion. However, if a taxpayer has multiple short coverage gaps due to extended waiting periods after switching employment or because of other circumstances that prevent the taxpayer from obtaining coverage, the taxpayer may be eligible for a hardship or other exemption available through an Exchange. See 45 CFR 155.605.

Section 5000A(e)(4)(B)(i) provides that, in general, the length of a continuous period without coverage is determined without regard to the calendar years in which the period occurs. However, section 5000A(e)(4) expressly authorizes the Secretary of the Treasury to prescribe rules for the collection of the shared responsibility payment in cases in which a continuous period includes months in more than one taxable year. The proposed regulations provide rules for a coverage gap that straddles two taxable years. For the earlier taxable year, the coverage gap terminates at the end of the earlier taxable year. For the later taxable year, the coverage gap continues from the earlier taxable year and terminates when the individual no longer lacks minimum essential coverage. Thus, a taxpayer who lacked minimum essential coverage in November and December of one year and January and February of the following year has a coverage gap of two months in the earlier taxable year and four months in the later taxable year.

Some commentators stated that the coverage gap in the earlier year should include months in the later year in which an individual has no minimum essential coverage. Other commentators recommended that all continuous periods in a year begin no earlier than January 1, thereby ignoring any gaps in coverage in the preceding year. The final regulations adopt neither suggestion. To assist taxpayers in timely filing returns and in the interests of efficient tax administration, the final regulations provide that a continuous period terminates no later than the last day of a taxable year. In addition, for the later year when the same administrative concerns do not apply, consistent with section 5000A(e)(4)(B)(i), the final regulations provide that a continuous

period may include months in an earlier year.

Under the proposed regulations an individual has minimum essential coverage for a month in which the individual is otherwise exempt from section 5000A for the short coverage gap exemption. One commentator asked whether gaps in coverage in 2013 affect the measurement of gaps in coverage beginning in January 2014. Section 5000A is effective for months beginning on or after January 1, 2014. Accordingly, the final regulations provide that gaps in coverage prior to January 1, 2014, are not taken into account when measuring the length of a coverage gap in 2014.

A commentator requested that any probationary period during which an individual is enrolled in minimum essential coverage but not yet entitled to benefits under the plan not be taken into account in determining the length of a continuous period for the short coverage gap exemption. As discussed in this preamble with regard to a similar comment concerning a taxpayer who submitted an application for Medicaid but is awaiting approval for enrollment, section 5000A(a) requires that an individual have minimum essential coverage for the month. Unless retroactive coverage is provided, an applicant awaiting approval for enrollment is not covered until approval of the application. Therefore, the final regulations do not adopt this recommendation. However, an individual who is unable to obtain coverage in a timely manner because of a lengthy approval process may be otherwise eligible for a hardship or other exemption through an Exchange. See 45 CFR 155.605.

I. Additional Hardship Exemptions

A number of commentators proposed that the IRS adopt additional hardship exemptions to address specific situations. Authority to define circumstances giving rise to a hardship exemption, as well as authority to grant hardship exemptions in individual cases, resides with HHS. HHS has provided guidance on the hardship exemption in the HHS MEC regulations.

Section 155.605(g)(3) of the HHS MEC regulations provides that the IRS may allow a taxpayer to claim a hardship exemption for a calendar year if the taxpayer was not required to file an income tax return because the taxpayer's gross income was below the applicable return filing threshold but nevertheless filed a return, claimed a dependent with a return filing requirement and, as a result, had household income that exceeds the applicable filing threshold.

Section 155.605(g)(5) of the HHS MEC regulations provides that the IRS may allow a taxpayer to claim a hardship exemption for employed family members who are eligible for affordable employer-sponsored self-only coverage, but for whom the aggregate cost of employer-sponsored coverage for all employed members of the family is unaffordable.

The information required to determine eligibility for these hardship exemptions is available only at the time of tax filing. Accordingly, the final regulations provide that eligible taxpayers may claim these two hardship exemptions on a Federal income tax return.

J. Claiming Exemptions From the Shared Responsibility Payment

Section 1.5000A–3(k) of the proposed regulations addresses which exemptions may be certified by an Exchange or claimed on a return, and how to claim exemptions. The HHS MEC regulations address how to request certification for an exemption from an Exchange. The manner for claiming an exemption on a return is more appropriately addressed through IRS forms, instructions, or other publications. Therefore, the final regulations do not provide information on how to claim an exemption on a Federal income tax return.

IV. Accuracy-Related Penalties

One commentator expressed concern that taxpayers would have difficulty accurately calculating the shared responsibility payment. Emphasizing the complexity of the calculation, the commentator requested that the IRS not impose accuracy-related penalties under section 6662 for underpayments caused by erroneous section 5000A computations.

Section 6662 does not apply to a section 5000A shared responsibility payment. The accuracy-related penalty of section 6662(a) applies only to underpayments of tax, defined in section 6664. The section 5000A shared responsibility payment is not taken into consideration in determining whether there is an underpayment of tax under section 6664. Therefore, the shared responsibility payment is not taken into account under section 6662. Forms, instructions, publications, or other guidance to be published by the IRS are anticipated to assist taxpayers in determining the amount of an applicable shared responsibility payment.

V. Effective/Applicability Date

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

Special Analyses

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

Drafting Information

The principal authors of these final regulations are Sue-Jean Kim and John B. Lovelace of the Office of Associate Chief Counsel (Income Tax and Accounting). Other personnel from the IRS and the Treasury Department participated in their development.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

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

PART 1—INCOME TAXES

■ **Paragraph 1.** The authority citation for part 1 is amended by adding an entry in numerical order to read in part as follows:

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

Section 1.5000A–4 also issued under 26 U.S.C. 5000A(e)(4).

■ **Par 2.** Sections 1.5000A–0 through 1.5000A–5 are added to read as follows:

§ 1.5000A–0 Table of contents.

This section lists the captions contained in §§ 1.5000A–1 through 1.5000A–5.

§ 1.5000A–1 Maintenance of minimum essential coverage and liability for the shared responsibility payment.

(a) *In general.* For each month during the taxable year, a nonexempt

individual must have minimum essential coverage or pay the shared responsibility payment. For a month, a nonexempt individual is an individual in existence for the entire month who is not an exempt individual described in § 1.5000A–3.

(b) *Coverage under minimum essential coverage*—(1) *In general.* An individual has minimum essential coverage for a month in which the individual is enrolled in and entitled to receive benefits under a program or plan identified as minimum essential coverage in § 1.5000A–2 for at least one day in the month.

(2) *Special rule for United States citizens or residents residing outside the United States or residents of territories.* An individual is treated as having minimum essential coverage for a month—

(i) If the month occurs during any period described in section 911(d)(1)(A) or section 911(d)(1)(B) that is applicable to the individual; or

(ii) If, for the month, the individual is a bona fide resident of a possession of the United States (as determined under section 937(a)).

(c) *Liability for shared responsibility payment*—(1) *In general.* A taxpayer is liable for the shared responsibility payment for a month for which—

(i) The taxpayer is a nonexempt individual without minimum essential coverage; or

(ii) A nonexempt individual for whom the taxpayer is liable under paragraph (c)(2) or (c)(3) of this section does not have minimum essential coverage.

(2) *Liability for dependents*—(i) *In general.* For a month when a nonexempt individual does not have minimum essential coverage, if the nonexempt individual is a dependent (as defined in section 152) of another individual for the other individual's taxable year including that month, the other individual is liable for the shared responsibility payment attributable to the dependent's lack of coverage. An individual is a dependent of a taxpayer for a taxable year if the individual satisfies the definition of dependent under section 152, regardless of whether the taxpayer claims the individual as a dependent on a Federal income tax return for the taxable year. If an individual may be claimed as a dependent by more than one taxpayer in the same calendar year, the taxpayer who properly claims the individual as a dependent for the taxable year is liable for the shared responsibility payment attributable to the individual. If more than one taxpayer may claim an individual as a dependent in the same calendar year but no one claims the individual as a dependent, the taxpayer with priority under the rules of section 152 to claim the individual as a dependent is liable for the shared responsibility payment for the individual.

(ii) *Special rules for dependents adopted or placed in foster care during the taxable year*—(A) *Taxpayers adopting an individual.* If a taxpayer adopts a nonexempt dependent (or accepts a nonexempt dependent who is an eligible foster child as defined in section 152(f)(1)(C)) during the taxable year and is otherwise liable for the nonexempt dependent under paragraph (c)(2)(i) of this section, the taxpayer is liable under paragraph (c)(2)(i) of this section for the nonexempt dependent only for the full months in the taxable year that follow the month in which the adoption or acceptance occurs.

(B) *Taxpayers placing an individual for adoption.* If a taxpayer who is otherwise liable for a nonexempt dependent under paragraph (c)(2)(i) of this section places (or, by operation of law, must place) the nonexempt dependent for adoption or foster care during the taxable year, the taxpayer is liable under paragraph (c)(2)(i) of this section for the nonexempt dependent only for the full months in the taxable year that precede the month in which the adoption or foster care placement occurs.

(C) *Examples.* The following examples illustrate the provisions of this paragraph (c)(2)(ii). In each example the taxpayer's taxable year is a calendar year.

Example 1. Taxpayers adopting a child. (i) E and F, married individuals filing a joint return, initiate proceedings for the legal adoption of a 2-year old child, G, in January 2016. On May 15, 2016, G becomes the adopted child (within the meaning of section 152(f)(1)(B)) of E and F, and resides with them for the remainder of 2016. Prior to the adoption, G resides with H, an unmarried individual, with H providing all of G's support. For 2016 G meets all requirements under section 152 to be E and F's dependent, and not H's dependent.

(ii) Under paragraph (c)(2) of this section, E and F are not liable for a shared responsibility payment attributable to G for January through May of 2016, but are liable for a shared responsibility payment attributable to G, if any, for June through December of 2016. H is not liable for a shared responsibility payment attributable to G for any month in 2016, because G is not H's dependent for 2016 under section 152.

Example 2. Taxpayers placing a child for adoption. (i) The facts are the same as *Example 1,* except the legal adoption occurs on August 15, 2016, and, for 2016, G meets all requirements under section 152 to be H's dependent, and not E and F's dependent.

(ii) Under paragraph (c)(2) of this section, H is liable for a shared responsibility payment attributable to G, if any, for January through July of 2016, but is not liable for a shared responsibility payment attributable to G for August through December of 2016. E and F are not liable for a shared responsibility payment attributable to G for any month in 2016, because G is not E and F's dependent for 2016 under section 152.

(3) *Liability of individuals filing a joint return.* Married individuals (within the meaning of section 7703) who file a joint return for a taxable year are jointly liable for any shared responsibility payment for a month included in the taxable year.

(d) *Definitions.* The definitions in this paragraph (d) apply to this section and §§ 1.5000A–2 through 1.5000A–5.

(1) *Affordable Care Act. Affordable Care Act* refers to the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), as amended.

(2) *Employee. Employee* includes former employees.

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

(4) *Family.* A taxpayer's family means the individuals for whom the taxpayer properly claims a deduction for a personal exemption under section 151 for the taxable year.

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

(6) *Group health insurance coverage. Group health insurance coverage* has the same meaning as in section 2791(b) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(4)).

(7) *Group health plan. Group health plan* has the same meaning as in section 2791(a) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)).

(8) *Health insurance coverage. Health insurance coverage* has the same meaning as in section 2791(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(1)).

(9) *Health insurance issuer. Health insurance issuer* has the same meaning as in section 2791(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(2)).

(10) *Household income*—(i) *In general. Household income* means the sum of—

(A) A taxpayer's modified adjusted gross income; and

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

(*1*) Are included in the taxpayer's family under paragraph (d)(4) of this section; and

(*2*) Are required to file a Federal income tax return for the taxable year.

(ii) *Modified adjusted gross income. Modified adjusted gross income* means adjusted gross income (within the meaning of section 62) increased by—

(A) Amounts excluded from gross income under section 911; and

(B) Tax-exempt interest the taxpayer receives or accrues during the taxable year.

(11) *Individual market. Individual market* has the same meaning as in section 1304(a)(2) of the Affordable Care Act (42 U.S.C. 18024(a)(2)).

(12) *Large and small group market. Large group market* and *small group market* have the same meanings as in section 1304(a)(3) of the Affordable Care Act (42 U.S.C. 18024(a)(3)).

(13) *Month. Month* means calendar month.

(14) *Qualified health plan. Qualified health plan* has the same meaning as in section 1301(a) of the Affordable Care Act (42 U.S.C. 18021(a)).

(15) *Rating area. Rating area* has the same meaning as in § 1.36B–1(n).

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

(17) *Shared responsibility family. Shared responsibility family* means, for a month, all nonexempt individuals for whom the taxpayer (and the taxpayer's spouse, if the taxpayer is married and files a joint return with the spouse) is liable for the shared responsibility payment under paragraph (c) of this section.

(18) *State. State* means each of the 50 states and the District of Columbia.

§ 1.5000A–2 Minimum essential coverage.

(a) *In general. Minimum essential coverage* means coverage under a government-sponsored program (described in paragraph (b) of this section), an eligible employer-sponsored plan (described in paragraph (c) of this section), a plan in the individual market (described in paragraph (d) of this section), a grandfathered health plan (described in paragraph (e) of this section), or other health benefits coverage (described in paragraph (f) of this section). Minimum essential coverage does not include coverage described in paragraph (g) of this section. All terms defined in this section apply for purposes of this section and § 1.5000A–1 and §§ 1.5000A–3 through 1.5000A–5.

(b) *Government-sponsored program*—(1) *In general.* Except as provided in paragraph (2), *government-sponsored program* means any of the following:

(i) *Medicare.* The Medicare program under part A of Title XVIII of the Social Security Act (42 U.S.C. 1395c and following sections);

(ii) *Medicaid.* The Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1396 and following sections), other than—

(A) Optional coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XXI));

(B) Optional coverage of tuberculosis-related services under section 1902(a)(10)(A)(ii)(XII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XII));

(C) Coverage of pregnancy-related services under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)); or

(D) Coverage limited to treatment of emergency medical conditions in accordance with 8 U.S.C. 1611(b)(1)(A), as authorized by section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)).

(iii) *Children's Health Insurance Program.* The Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (42 U.S.C. 1397aa and following sections);

(iv) *TRICARE.* Medical coverage under chapter 55 of Title 10, U.S.C., including coverage under the TRICARE program.

(v) *Veterans programs.* The following health care programs under chapter 17 or 18 of Title 38, U.S.C.:

(A) The medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705;

(B) The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781; and

(C) The comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering from spina bifida.

(vi) *Peace Corp program.* A health plan under section 2504(e) of Title 22, U.S.C. (relating to Peace Corps volunteers); and

(vii) *Nonappropriated Fund Health Benefits Program.* 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 (Pub. L. 103–337; 10 U.S.C. 1587 note).

(2) *Government-sponsored program special rules*—(i) *Coverage authorized under Section 1115 of the Social Security Act.* [Reserved]

(ii) *Medicaid for the medically needy programs.* [Reserved]

(iii) *Limited benefits TRICARE programs.* [Reserved]

(c) *Eligible employer-sponsored plan*—(1) *In general. Eligible employer-sponsored plan* means, with respect to any employee:

(i) Group health insurance coverage offered by, or on behalf of, an employer to the employee that is—

(A) A governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act (42 U.S.C. 300gg–91(d)(8)));

(B) Any other plan or coverage offered in the small or large group market within a State;

(C) A grandfathered health plan (within the meaning of paragraph (e) of this section) offered in a group market; or

(ii) A self-insured group health plan under which coverage is offered by, or on behalf of, an employer to the employee.

(2) *Government-sponsored program generally not an eligible employer-sponsored plan.* Except for the program identified in paragraph (b)(7) of this section, a government-sponsored program described in paragraph (b) of this section is not an eligible employer-sponsored plan.

(d) *Plan in the individual market*—(1) *In general. Plan in the individual market* means health insurance coverage offered to individuals in the individual market within a state, other than short-term limited duration insurance within the meaning of section 2791(b)(5) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(5)).

(2) *Qualified health plan offered by an Exchange.* A qualified health plan offered by an Exchange is a plan in the individual market. If a territory of the United States elects to establish an Exchange under section 1323(a) and (b) of the Affordable Care Act (42 U.S.C. 18043(a)(1), (b)), a qualified health plan offered by that Exchange is a plan in the individual market.

(e) *Grandfathered health plan. Grandfathered health plan* means any group health plan or group health insurance coverage to which section 1251 of the Affordable Care Act (42 U.S.C. 18011) applies.

(f) *Other coverage that qualifies as minimum essential coverage.* Minimum essential coverage includes any plan or arrangement recognized by the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, as minimum essential coverage.

(g) *Excepted benefits not minimum essential coverage.* Minimum essential coverage does not include any health insurance coverage that consists solely

of excepted benefits described in section 2791(c)(1), (c)(2), (c)(3), or (c)(4) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

§ 1.5000A–3 Exempt individuals.

(a) *Members of recognized religious sects*—(1) *In general.* An individual is an exempt individual for a month that includes a day on which the individual has in effect a religious conscience exemption certification described in paragraph (a)(2) of this section.

(2) *Exemption certification.* A religious conscience exemption certification is issued by an Exchange in accordance with the requirements of section 1311(d)(4)(H) of the Affordable Care Act (42 U.S.C. 18031(d)(4)(H)), 45 CFR 155.605(c), and 45 CFR 155.615(b) and certifies that an individual is—

(i) A member of a recognized religious sect or division of the sect that is described in section 1402(g)(1); and

(ii) An adherent of established tenets or teachings of the sect or division as described in that section.

(b) *Member of health care sharing ministries*—(1) *In general.* An individual is an exempt individual for a month that includes a day on which the individual is a member of a health care sharing ministry.

(2) *Health care sharing ministry.* For purposes of this section, *health care sharing ministry* means an organization—

(i) That is described in section 501(c)(3) and is exempt from tax under section 501(a);

(ii) Members of which share a common set of ethical or religious beliefs and share medical expenses among themselves in accordance with those beliefs and without regard to the state in which a member resides or is employed;

(iii) Members of which retain membership even after they develop a medical condition;

(iv) That (or a predecessor of which) has been in existence at all times since December 31, 1999;

(v) Members of which have shared medical expenses continuously and without interruption since at least December 31, 1999; and

(vi) That conducts an annual audit performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and makes the annual audit report available to the public upon request.

(c) *Exempt noncitizens*—(1) *In general.* An individual is an exempt individual for a month that the individual is an exempt noncitizen.

(2) *Exempt noncitizens.* For purposes of this section, an individual is an exempt noncitizen for a month if the individual—

(i) Is not a U.S. citizen or U.S. national for any day during the month; and

(ii) Is either—

(A) A nonresident alien (within the meaning of section 7701(b)(1)(B)) for the taxable year that includes the month; or

(B) An individual who is not lawfully present (within the meaning of 45 CFR 155.20) on any day in the month.

(d) *Incarcerated individuals*—(1) *In general.* An individual is an exempt individual for a month that includes a day on which the individual is incarcerated.

(2) *Incarcerated.* For purposes of this section, the term *incarcerated* means confined, after the disposition of charges, in a jail, prison, or similar penal institution or correctional facility.

(e) *Individuals with no affordable coverage*—(1) *In general.* An individual is an exempt individual for a month in which the individual lacks affordable coverage. For purposes of this paragraph (e), an individual lacks affordable coverage in a month if the individual's required contribution (determined on an annual basis) for minimum essential coverage for the month exceeds the required contribution percentage (as defined in paragraph (e)(2) of this section) of the individual's household income. For purposes of this paragraph (e), an individual's household income is increased by any amount of the required contribution made through a salary reduction arrangement that is excluded from gross income.

(2) *Required contribution percentage*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, the required contribution percentage is 8 percent.

(ii) *Indexing.* For plan years beginning in any calendar year after 2014, the required contribution percentage is the percentage determined by the Department of Health and Human Services that reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for the period.

(iii) *Plan year.* For purposes of this paragraph (e), *plan year* means the eligible employer-sponsored plan's regular 12-month coverage period, or for a new employee or an individual who enrolls during a special enrollment period, the remainder of a 12-month coverage period.

(3) *Individuals eligible for coverage under eligible employer-sponsored plans*—(i) *Eligibility*—(A) *In general.* Except as provided in paragraph (e)(3)(i)(B) of this section, an employee or related individual (as defined in paragraph (e)(3)(ii)(B) of this section) is treated as eligible for 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 any day in that month during an open or special enrollment period, regardless of whether the employee or related individual is eligible for any other type of minimum essential coverage.

(B) *Multiple eligibility.* For purposes of this paragraph (e)(3), an employee eligible for coverage under an eligible employer-sponsored plan offered by the employee's employer is not treated as eligible as a related individual for coverage under an eligible employer-sponsored plan (for example, an eligible employer-sponsored plan offered by the employer of the employee's spouse) for any month included in the plan year of the eligible employer-sponsored plan offered by the employee's employer.

(C) *Special rule for post-employment coverage.* A former employee or an individual related to a former employee, who may enroll in continuation coverage required under Federal law or a state law that provides comparable continuation coverage, or in retiree coverage under an eligible employer-sponsored plan, is eligible for coverage under an eligible employer-sponsored plan only if the individual enrolls in the coverage.

(ii) *Required contribution for individuals eligible for coverage under an eligible employer-sponsored plan*—(A) *Employees.* In the case of an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.

(B) *Individuals related to employees.* In the case of an individual who is eligible for coverage under an eligible employer-sponsored plan because of a relationship to an employee and for whom a personal exemption deduction under section 151 is claimed on the employee's Federal income tax return (related individual), the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all related individuals who are included in the employee's family and are not otherwise exempt under § 1.5000A–3.

(C) *Required contribution for part-year period.* For each individual

described in paragraph (e)(3)(ii)(A) or (e)(3)(ii)(B) of this section, affordability under this paragraph (e)(3) 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 the individual. Coverage under an eligible employer-sponsored plan is affordable for a part-year period if the annualized required contribution for self-only coverage (in the case of the employee) or family coverage (in the case of a related individual) under the plan for the part-year period does not exceed the required contribution percentage of the individual's household income for the taxable year. The annualized required contribution is the required contribution determined under paragraph (e)(3)(ii)(A) or (e)(3)(ii)(B) of this section 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 individual's taxable year. Only full calendar months are included in the computation under this paragraph (e)(3)(ii)(C).

(D) *Employer contributions to health reimbursement arrangements.* [Reserved]

(E) *Wellness program incentives.* [Reserved]

(iii) *Examples.* The following examples illustrate the application of this paragraph (e)(3). Unless stated otherwise, in each example, each individual's taxable year is a calendar year, the individual is ineligible for any other exemptions described in this section for a month, the rate of premium growth has not exceeded the rate of income growth since 2013, and the individual's employer offers a single plan that uses a calendar plan year and is an eligible employer-sponsored plan as described in § 1.5000A–2(c).

Example 1. Unmarried employee with no dependents. Taxpayer A is an unmarried individual with no dependents. In November 2015, A is eligible to enroll in self-only coverage under a plan offered by A's employer for calendar year 2016. If A enrolls in the coverage, A is required to pay $5,000 of the total annual premium. In 2016, A's household income is $60,000. Under paragraph (e)(3)(ii)(A) of this section, A's required contribution is $5,000, the portion of the annual premium A pays for self-only coverage. Under paragraph (e)(1) of this section, A lacks affordable coverage for 2016 because A's required contribution ($5,000) is greater than 8% of A's household income ($4,800).

Example 2. Married employee with dependents. Taxpayers B and C are married and file a joint return for 2016. B and C have two children, D and E. In November 2015, B is eligible to enroll in self-only coverage under a plan offered by B's employer for calendar year 2016 at a cost of $5,000 to B. C, D, and E are eligible to enroll in family coverage under the same plan for 2016 at a cost of $20,000 to B. B, C, D, and E's household income for 2016 is $90,000. Under paragraph (e)(3)(ii)(A) of this section, B's required contribution is B's share of the cost for self-only coverage, $5,000. Under paragraph (e)(1) of this section, B has affordable coverage for 2016 because B's required contribution ($5,000) does not exceed 8% of B's household income ($7,200). Under paragraph (e)(3)(ii)(B) of this section, the required contribution for C, D, and E is B's share of the cost for family coverage, $20,000. Under paragraph (e)(1) of this section, C, D, and E lack affordable coverage for 2016 because their required contribution ($20,000) exceeds 8% of their household income ($7,200).

Example 3. Plan year is a fiscal year. (i) Taxpayer F is an unmarried individual with no dependents. In June 2015, F is eligible to enroll in self-only coverage under a plan offered by F's employer for the period July 2015 through June 2016 at a cost to F of $4,750. In June 2016, F is eligible to enroll in self-only coverage under a plan offered by F's employer for the period July 2016 through June 2017 at a cost to F of $5,000. In 2016, F's household income is $60,000.

(ii) Under paragraph (e)(3)(ii)(C) of this section, F's annualized required contribution for the period January 2016 through June 2016 is $4,750 ($2,375 paid for premiums in 2016 × 12/6). Under paragraph (e)(1) of this section, F has affordable coverage for January 2016 through June 2016 because F's annualized required contribution ($4,750) does not exceed 8% of F's household income ($4,800).

(iii) Under paragraph (e)(3)(ii)(C) of this section, F's annualized required contribution for the period July 2016 to December 2016 is $5,000 ($2,500 paid for premiums in 2016 × 12/6). Under paragraph (e)(1) of this section, F lacks affordable coverage for July 2016 through December 2016 because F's annualized required contribution ($5,000) exceeds 8% of F's household income ($4,800).

Example 4. Eligibility for coverage under an eligible employer-sponsored plan and under government sponsored coverage. Taxpayer G is unmarried and has one child, H. In November 2015, H is eligible to enroll in family coverage under a plan offered by G's employer for 2016. H is also eligible to enroll in the CHIP program for 2016. Under paragraph (e)(3)(i) of this section, H is treated as eligible for coverage under an eligible employer-sponsored plan for each month in 2016, notwithstanding that H is eligible to enroll in government sponsored coverage for the same period.

(4) *Individuals ineligible for coverage under eligible employer-sponsored plans*—(i) *Eligibility for coverage other than an eligible employer-sponsored plan.* An individual is treated as ineligible for coverage under an eligible employer-sponsored plan for a month that is not described in paragraph (e)(3)(i) of this section.

(ii) *Required contribution for individuals ineligible for coverage under eligible employer-sponsored plans*—(A) *In general.* In the case of an individual who is ineligible for coverage under an eligible employer-sponsored plan, the required contribution is the premium for the applicable plan, reduced by the maximum amount of any credit allowable under section 36B for the taxable year, determined as if the individual was covered for the entire taxable year by a qualified health plan offered through the Exchange serving the rating area where the individual resides.

(B) *Applicable plan*—(*1*) *In general.* Except as provided in paragraph (e)(4)(ii)(B)(*2*) of this section, *applicable plan* means the single lowest cost bronze plan available in the individual market through the Exchange serving the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange) that would cover all individuals in the individual's nonexempt family. For purposes of this paragraph (e)(4), an individual's *nonexempt family* means the family (as defined in § 1.5000A–1(d)(4)) that includes the individual, excluding any family members who are otherwise exempt under section 1.5000A–3 or are treated as eligible for coverage under an eligible employer-sponsored plan under paragraph (e)(3)(i) of this section. The premium for the applicable plan takes into account rating factors (for example, an individual's age or tobacco use) that an Exchange would use to determine the cost of coverage.

(*2*) *Lowest cost bronze plan does not cover all individuals included in the taxpayer's nonexempt family*—(*i*) *In general.* If the Exchange serving the rating area where the individual resides does not offer a single bronze plan covering all individuals included in the individual's nonexempt family, the premium for the applicable plan is the sum of the premiums for the lowest cost bronze plans that are offered through the Exchanges serving the rating areas where one or more of the individuals reside that would cover in the aggregate all the individuals in the individual's nonexempt family. For instance, coverage offered through the Exchange in a rating area might not cover a family member living in different rating area or a single policy might not cover all the members in a taxpayer's household.

(*ii*) *Optional simplified method for applicable plan identification.* [Reserved]

(C) *Credit allowable under section 36B.* For purposes of paragraph (e)(4)(ii)(A) of this section, *maximum amount of any credit allowable under section 36B* means the maximum amount of the credit that would be allowable to the individual, or to the taxpayer who can properly claim the individual as a dependent, under section 36B if all members of the individual's nonexempt family enrolled in a qualified health plan through the Exchange serving the rating area where the individual resides.

(D) *Required contribution for part-year period.* For each individual described in paragraph (e)(4)(ii)(A) of this section, affordability under paragraph (e)(4) of this section is determined separately for each period described in paragraph (e)(4)(ii)(E) of this section that is less than a 12-month period. Coverage under a plan is affordable for a part-year period if the annualized required contribution for coverage under the plan for the part-year period does not exceed the required contribution percentage of the individual's household income for the taxable year. The annualized required contribution is the required contribution determined under paragraph (e)(4)(ii)(A) of this section 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 individual's taxable year. Only full calendar months are included in the computation under this paragraph (e)(4)(ii)(D).

(iii) *Examples.* The following examples illustrate the provisions of this paragraph (e)(4). Unless stated otherwise, in each example the taxpayer's taxable year is a calendar year, the rate of premium growth has not exceeded the rate of income growth since 2013, and the taxpayer is ineligible for any of the exemptions described in paragraphs (b) through (i) of this section for a month.

Example 1. Unmarried employee with no dependents. (i) Taxpayer G is an unmarried individual with no dependents. G is ineligible to enroll in any minimum essential coverage other than coverage in the individual market for all months in 2016. The annual premium for the lowest cost bronze self-only plan in G's rating area (G's applicable plan) is $5,000. The adjusted annual premium for the second lowest cost silver self-only plan in G's rating area (G's applicable benchmark plan within the meaning of § 1.36B–3(f)) is $5,500. In 2016 G's household income is $40,000, which is 358% of the Federal poverty line for G's family size for the taxable year.

(ii) Under paragraph (e)(4)(ii)(C) of this section, the credit allowable under section 36B is determined pursuant to section 36B. With household income at 358% of the Federal poverty line, G's applicable percentage is 9.5. Because each month in 2016 is a coverage month (within the meaning of § 1.36B–3(c)), G's maximum credit allowable under section 36B is the excess of G's premium for the applicable benchmark plan over the product of G's household income and G's applicable percentage ($1,700). Therefore, under paragraph (e)(4)(ii)(A) of this section, G's required contribution is $3,300. Under paragraph (e)(1) of this section, G lacks affordable coverage for 2016 because G's required contribution ($3,300) exceeds 8% of G's household income ($3,200).

Example 2. Family. (i) In 2016 Taxpayers M and N are married and file a joint return. M and N have two children, P and Q. M, N, P, and Q are ineligible to enroll in minimum essential coverage other than coverage in the individual market for a month in 2016. The annual premium for M, N, P, and Q's applicable plan is $20,000. The adjusted annual premium for M, N, P, and Q's applicable benchmark plan (within the meaning of § 1.36B–3(f)) is $25,000. M and N's household income is $80,000, which is 347% of the Federal poverty line for a family size of 4 for the taxable year.

(ii) Under paragraph (e)(4)(ii)(C) of this section, the credit allowable under section 36B is determined pursuant to section 36B. With household income at 347% of the Federal poverty line, the applicable percentage is 9.5. Because each month in 2016 is a coverage month (within the meaning of § 1.36B–3(c)), the maximum credit allowable under section 36B is the excess of the premium for the applicable benchmark plan over the product of the household income and the applicable percentage ($17,400). Therefore, under paragraph (e)(4)(ii)(A) of this section, the required contribution for M, N, P, and Q is $2,600. Under paragraph (e)(1) of this section, M, N, P, and Q have affordable coverage for 2016 because their required contribution ($2,600) does not exceed 8% of their household income ($6,400).

Example 3. Family with some members eligible for government-sponsored coverage. (i) In 2016 Taxpayers U and V are married and file a joint return. U and V have two children, W and X. U and V are ineligible to enroll in minimum essential coverage other than coverage in the individual market for all months in 2016; however, W and X are eligible for coverage under CHIP for 2016. The annual premium for U, V, W, and X's applicable plan is $20,000. The adjusted annual premium for the second lowest cost silver plan that would cover U and V (the applicable benchmark plan within the meaning of § 1.36B–3(f)) is $12,500. U and V's household income is $50,000, which is 217% of the Federal poverty line for a family size of 4 for the taxable year. W and X do not enroll in CHIP coverage.

(ii) Under paragraph (e)(4)(ii)(C) of this section, the credit allowable under section 36B is determined pursuant to section 36B. With household income at 217% of the Federal poverty line, the applicable percentage is 6.89. Each month in 2016 is a coverage month (within the meaning of § 1.36B–3(c)) for U and V, but no months in 2016 are coverage months for W and X because they are eligible for CHIP coverage. The maximum credit allowable under section 36B is the excess of the premium for the applicable benchmark plan over the product of the household income and the applicable percentage ($9,055). Therefore, under paragraph (e)(4)(ii)(A) of this section, the required contribution is $10,945. Under paragraph (e)(1) of this section, U, V, W, and X lack affordable coverage for 2016 because their required contribution ($10,945) exceeds 8% of their household income ($4,000).

Example 4. Family with some members enrolled in government-sponsored minimum essential coverage. The facts are the same as *Example 3,* except W and X enroll in CHIP coverage on January 1, 2016. Under paragraph (e)(4)(ii)(B), U, V, W, and X are members of U and V's nonexempt family for 2016. Therefore, the annual premium for the applicable plan is the same as in *Example 3* ($20,000). The maximum credit allowable under section 36B is also the same as in *Example 3* ($9,055). Under paragraph (e)(4)(ii)(A) of this section, the required contribution is $10,945. Under paragraph (e)(1) of this section, U and V lack affordable coverage for 2016 because their required contribution ($10,945) exceeds 8% of their household income ($4,000).

(f) *Household income below filing threshold*—(1) *In general.* An individual is an exempt individual for any taxable year for which the individual's household income is less than the applicable filing threshold.

(2) *Applicable filing threshold*—(i) *In general.* For purposes of this section, *applicable filing threshold* means the amount of gross income that would trigger an individual's requirement to file a Federal income tax return under section 6012(a)(1).

(ii) *Certain dependents.* The applicable filing threshold for an individual who is properly claimed as a dependent by another taxpayer is equal to the other taxpayer's applicable filing threshold.

(3) *Manner of claiming the exemption.* A taxpayer is not required to file a Federal income tax return solely to claim the exemption described in this paragraph (f). If a taxpayer has a household income below the applicable filing threshold and nevertheless files a Federal income tax return, the taxpayer may claim the exemption described in this paragraph (f) on the return.

(g) *Members of Indian tribes.* An individual is an exempt individual for a month that includes a day on which the individual is a member of an Indian tribe. For purposes of this section, *Indian tribe* means a group or community described in section 45A(c)(6).

(h) *Individuals with hardship exemption certification*—(1) *In general.* An individual is an exempt individual

for a month that includes a day on which the individual has in effect a hardship exemption certification described in paragraph (h)(2) of this section.

(2) *Hardship exemption certification.* A hardship exemption certification is issued by an Exchange under section 1311(d)(4)(H) of the Affordable Care Act (42 U.S.C. 18031(d)(4)(H)), 45 CFR 155.605(g)(1), (g)(2), (g)(4) and (g)(6), 45 CFR 155.610(i), and 45 CFR 155.615(f), and certifies that an individual has suffered a hardship (as that term is defined in 45 CFR 155.605(g)) affecting the capability to obtain minimum essential coverage.

(3) *Hardship exemptions that may be claimed on a return.* A taxpayer who meets the requirements of 45 CFR 155.605(g)(3) or 45 CFR 155.605(g)(5) may claim a hardship exemption for a calendar year on a Federal income tax return.

(i) [Reserved]

(j) *Individuals with certain short coverage gaps*—(1) *In general.* An individual is an exempt individual for a month the last day of which is included in a short coverage gap.

(2) *Short coverage gap*—(i) *In general. Short coverage gap* means a continuous period of less than three months in which the individual is not covered under minimum essential coverage. If the individual does not have minimum essential coverage for a continuous period of three or more months, none of the months included in the continuous period are treated as included in a short coverage gap.

(ii) *Coordination with other exemptions.* For purposes of this paragraph (j), an individual is treated as having minimum essential coverage for a month in which an individual is exempt under any of paragraphs (a) through (h) of this section.

(iii) *More than one short coverage gap during calendar year.* If a calendar year includes more than one short coverage gap, the exemption provided by this paragraph (j) only applies to the earliest short coverage gap.

(3) *Continuous period*—(i) *In general.* Except as provided in paragraph (j)(3)(ii) of this section, the number of months included in a continuous period is determined without regard to the calendar years in which months included in that period occur. For purposes of paragraph (j) of this section, a continuous period begins no earlier than January 1, 2014.

(ii) *Continuous period straddling more than one taxable year.* If an individual does not have minimum essential coverage for a continuous period that begins in one taxable year and ends in the next, for purposes of applying this paragraph (j) to the first taxable year, the months in the second taxable year included in the continuous period are disregarded. For purposes of applying this paragraph (j) to the second taxable year, the months in the first taxable year included in the continuous period are taken into account.

(4) *Examples.* The following examples illustrate the provisions of this paragraph (j). Unless stated otherwise, in each example the taxpayer's taxable year is a calendar year and the taxpayer is ineligible for any of the exemptions described in paragraphs (a) through (h) of this section for a month.

Example 1. Short coverage gap. Taxpayer D has minimum essential coverage in 2016 from January 1 through March 2. After March 2, D does not have minimum essential coverage until D enrolls in an eligible employer-sponsored plan effective June 15. Under § 1.5000A–1(b), for purposes of section 5000A, D has minimum essential coverage for January, February, March, and June through December. D's continuous period without coverage is 2 months, April and May. April and May constitute a short coverage gap under paragraph (j)(2)(i) of this section.

Example 2. Continuous period of 3 months or more. The facts are the same as in *Example 1,* except D's coverage is not effective until July 1. D's continuous period without coverage is 3 months, April, May, and June. Under paragraph (j)(2)(i) of this section, April, May, and June are not included in a short coverage gap.

Example 3. Short coverage gap following exempt period. Taxpayer E is incarcerated from January 1 through June 2. E enrolls in an eligible employer-sponsored plan effective September 15. Under paragraph (d) of this section, E is exempt for the period January through June. Under paragraph (j)(2)(ii) of this section, E is treated as having minimum essential coverage for this period, and E's continuous period without minimum essential coverage is 2 months, July and August. July and August constitute a short coverage gap under paragraph (j)(2)(i) of this section.

Example 4. Continuous period covering more than one taxable year. Taxpayer F, an unmarried individual with no dependents, has minimum essential coverage for the period January 1 through October 15, 2016. F is without coverage until February 15, 2017. F files his Federal income tax return for 2016 on March 10, 2017. Under paragraph (j)(3)(ii) of this section, November and December of 2016 are treated as a short coverage gap. However, November and December of 2016 are included in the continuous period that includes January 2017. The continuous period for 2017 is not less than 3 months and, therefore, January is not a part of a short coverage gap.

Example 5. Enrollment following loss of coverage. The facts are the same as in *Example 4* except F loses coverage on June 15, 2017. F enrolls in minimum essential coverage effective September 15, 2017. The continuous period without minimum essential coverage in July and August of 2017 is two months and, therefore, is a short coverage gap. Because January 2017 was not part of a short coverage gap, the earliest short coverage gap occurring in 2017 is the gap that includes July and August.

Example 6. Multiple coverage gaps. (i) The facts are the same as in *Example 5* except F has minimum essential coverage for November 2016. Under paragraph (j)(3)(ii) of this section, December 2016 is treated as a short coverage gap.

(ii) December 2016 is included in the continuous period that includes January 2017. This continuous period is two months and, therefore, January 2017 is the earliest month in 2017 that is included in a short coverage gap. Under paragraph (j)(2)(iii) of this section, the exemption under this paragraph (j) applies only to January 2017. Thus, the continuous period without minimum essential coverage in July and August of 2017 is not a short coverage gap.

§ 1.5000A–4 Computation of shared responsibility payment.

(a) *In general.* For each taxable year the shared responsibility payment is the lesser of—

(1) The sum of the monthly penalty amounts for each individual in the shared responsibility family; or

(2) The sum of the monthly national average bronze plan premiums for the shared responsibility family.

(b) *Monthly penalty amount*—(1) *In general. Monthly penalty amount* means, for a month that a nonexempt individual is not covered under minimum essential coverage, 1/12 multiplied by the greater of—

(i) The flat dollar amount; or

(ii) The excess income amount.

(2) *Flat dollar amount*—(i) *In general. Flat dollar amount* means the lesser of—

(A) The sum of the applicable dollar amounts for all individuals included in the taxpayer's shared responsibility family; or

(B) 300 percent of the applicable dollar amount (determined without regard to paragraph (b)(2)(iii) of this section) for the calendar year with or within which the taxable year ends.

(ii) *Applicable dollar amount.* Except as provided in paragraphs (b)(2)(iii) and (b)(2)(iv) of this section, the applicable dollar amount is—

(A) $95 in 2014;

(B) $325 in 2015; or

(C) $695 in 2016.

(iii) *Special applicable dollar amount for individuals under age 18.* If an individual has not attained the age of 18 before the first day of a month, the applicable dollar amount for the individual is equal to one-half of the applicable dollar amount (as expressed in paragraph (b)(2)(ii) of this section) for the calendar year in which the month

occurs. For purposes of this paragraph (b)(2)(iii), an individual attains the age of 18 on the anniversary of the date when the individual was born. For example, an individual born on March 1, 1999, attains the age of 18 on March 1, 2017.

(iv) *Indexing of applicable dollar amount.* In any calendar year after 2016, the applicable dollar amount is $695 as increased by the product of $695 and the cost-of-living adjustment determined under section 1(f)(3) for the calendar year. For purposes of this paragraph (b)(2)(iv), the cost-of-living adjustment is determined by substituting ''calendar year 2015'' for ''calendar year 1992'' in section 1(f)(3)(B). If any increase under this paragraph (b)(2)(iv) is not a multiple of $50, the increase is rounded down to the next lowest multiple of $50.

(3) *Excess income amount*—(i) *In general. Excess income amount* means the product of—

(A) The excess of the taxpayer's household income over the taxpayer's applicable filing threshold (as defined in § 1.5000A–3(f)(2)); and

(B) The income percentage.

(ii) *Income percentage.* For purposes of this section, *income percentage* means—

(A) 1.0 percent for taxable years beginning in 2013;

(B) 1.0 percent for taxable years beginning in 2014;

(C) 2.0 percent for taxable years beginning in 2015; or

(D) 2.5 percent for taxable years beginning after 2015.

(c) *Monthly national average bronze plan premium. Monthly national average bronze plan premium* means, for a month for which a shared responsibility payment is imposed, 1/12 of the annual national average premium for qualified health plans that have a bronze level of coverage, would provide coverage for the taxpayer's shared responsibility family members who do not have minimum essential coverage for the month, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(d) *Examples.* The following examples illustrate the provisions of this section. In each example the taxpayer's taxable year is a calendar year and all members of the taxpayer's shared responsibility family are ineligible for any of the exemptions described in § 1.5000A–3 for a month.

Example 1. Unmarried taxpayer without minimum essential coverage. (i) In 2016, Taxpayer G is an unmarried individual with no dependents. G does not have minimum essential coverage for any month in 2016. G's household income is $120,000. G's applicable filing threshold is $12,000. The annual national average bronze plan premium for G is $5,000.

(ii) For each month in 2016, under paragraph (b)(2)(ii) of this section, G's applicable dollar amount is $695. Under paragraph (b)(2) of this section, G's flat dollar amount is $695 (the lesser of $695 and $2,085 ($695 × 3)). Under paragraph (b)(3) of this section, G's excess income amount is $2,700 (($120,000 − $12,000) × 0.025). Therefore, under paragraph (b)(1) of this section, the monthly penalty amount is $225 (the greater of $58 ($695/12) or $225 ($2,700/12)).

(iii) The sum of the monthly penalty amounts is $2,700 ($225 × 12). The sum of the monthly national average bronze plan premiums is $5,000 ($5,000/12 × 12). Therefore, under paragraph (a) of this section, the shared responsibility payment imposed on G for 2016 is $2,700 (the lesser of $2,700 or $5,000).

Example 2. Part-year coverage. The facts are the same as in *Example 1,* except G has minimum essential coverage for January through June. The sum of the monthly penalty amounts is $1,350 ($225 × 6). The sum of the monthly national average bronze plan premiums is $2,500 ($5,000/12 × 6). Therefore, under paragraph (a) of this section, the shared responsibility payment imposed on G for 2016 is $1,350 (the lesser of $1,350 or $2,500).

Example 3. Family without minimum essential coverage. (i) In 2016, Taxpayers H and J are married and file a joint return. H and J have three children: K, age 21, L, age 15, and M, age 10. No member of the family has minimum essential coverage for any month in 2016. H and J's household income is $250,000. H and J's applicable filing threshold is $24,000. The annual national average bronze plan premium for a family of 5 (3 adults, 2 children) is $15,000.

(ii) For each month in 2016, under paragraphs (b)(2)(ii) and (b)(2)(iii) of this section, the applicable dollar amount is $2,780 (($695 × 3 adults) + (($695/2) × 2 children)). Under paragraph (b)(2)(i) of this section, the flat dollar amount is $2,085 (the lesser of $2,780 and $2,085 ($695 × 3)). Under paragraph (b)(3) of this section, the excess income amount is $5,650 (($250,000 − $24,000) × 0.025). Therefore, under paragraph (b)(1) of this section, the monthly penalty amount is $470.83 (the greater of $173.75 ($2,085/12) or $470.83 ($5,650/12)).

(iii) The sum of the monthly penalty amounts is $5,650 ($470.83 × 12). The sum of the monthly national average bronze plan premiums is $15,000 ($15,000/12 × 12). Therefore, under paragraph (a) of this section, the shared responsibility payment imposed on H and J for 2016 is $5,650 (the lesser of $5,650 or $15,000).

Example 4. Change in shared responsibility family during the year. (i) The facts are the same as in *Example 3,* except J has minimum essential coverage for January through June. The annual national average bronze plan premium for a family of 4 (2 adults, 2 children) is $10,000.

(ii) For the period January through June 2016, under paragraphs (b)(2)(ii) and (b)(2)(iii) of this section the applicable dollar amount is $2,085 (($695 × 2 adults) + (($695/2) × 2 children)). Under paragraph (b)(2)(i) of this section, the flat dollar amount is $2,085 (the lesser of $2,085 or $2,085 ($695 × 3)).

(iii) For the period July through December 2016, the applicable dollar amount is $2,780 (($695 × 3 adults) + (($695/2) × 2 children)). Under paragraph (b)(2) of this section, the flat dollar amount is $2,085 (the lesser of $2,780 or $2,085 ($695 × 3)). Under paragraph (b)(3) of this section, the excess income amount is $5,650 (($250,000 − $24,000) × 0.025). Therefore, under paragraph (b)(1) of this section, for January through June the monthly penalty amount is $470.83 (the greater of $173.75 ($2,085/12) or $470.83 ($5,650/12)). The monthly penalty amount for July through December is $470.83 (the greater of $173.75 ($2,085/12) or $470.83 ($5,650/12)).

(iv) The sum of the monthly penalty amounts is $5,650 ($470.83 × 12). The sum of the monthly national average bronze plan premiums is $12,500 ((($10,000/12) × 6) + (($15,000/12) × 6))). Therefore, under paragraph (a) of this section, the shared responsibility payment imposed on H and J for 2016 is $5,650 (the lesser of $5,650 or $12,500).

Example 5. Eighteenth birthday during the year. (i) In 2016 Taxpayers S and T are married and file a joint return. S and T have one child, U, who turns 18 years old on June 28. S, T, and U do not enroll in, and as a result are not eligible to receive benefits under, affordable employer-sponsored coverage offered by T's employer for 2016. S and T's household income is $60,000. S and T's applicable filing threshold is $24,000. The annual national average bronze plan premium for a family of 3 (2 adults, 1 child) is $11,000.

(ii) For the period January through June 2016, under paragraphs (b)(2)(ii) and (b)(2)(iii) of this section, the applicable dollar amount is $1,737.50 (($695 × 2 adults) + ($695/2) × 1 child)). Under paragraph (b)(2) of this section, the flat dollar amount is $1,737.50 (the lesser of $1,737.50 or $2,085 ($695 × 3)).

(iii) For the period July through December 2016, the applicable dollar amount is $2,085 ($695 × 3). Under paragraph (b)(2) of this section, the flat dollar amount is $2,085 (the lesser of $2,085 or $2,085 ($695 × 3)). Under paragraph (b)(3) of this section, the excess income amount is $900 (($60,000 − $24,000) × 0.025). Therefore, under paragraph (b)(1) of this section, for January through June the monthly penalty amount is $144.79 (the greater of $144.79 ($1,737.50/12) or $75 ($900/12)). The monthly penalty amount for July through December is $173.75 (the greater of $173.75 ($2,085/12) or $75 ($900/12)).

(iv) The sum of the monthly penalty amounts is $1,911.24 (($144.79 × 6) + ($173.75 × 6)). The sum of the monthly national average bronze plan premiums is $11,000 ($11,000/12 × 12). Therefore, under paragraph (a) of this section, the shared responsibility payment imposed on H and J for 2016 is $1,911.24 (the lesser of $1,911.24 or $11,000).

§ 1.5000A–5 Administration and procedure.

(a) *In general.* A taxpayer's liability for the shared responsibility payment for a month must be reported on the taxpayer's Federal income tax return for the taxable year that includes the month. The period of limitations for assessing the shared responsibility payment is the same as that prescribed by section 6501 for the taxable year to which the Federal income tax return on which the shared responsibility payment is to be reported relates. The shared responsibility payment is payable upon notice and demand by the Secretary, and except as provided in paragraph (b) of this section, is assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68 of the Internal Revenue Code. The shared responsibility payment is not subject to deficiency procedures of subchapter B of chapter 63 of the Internal Revenue Code. Interest on this payment accrues in accordance with the rules in section 6601.

(b) *Special rules.* Notwithstanding any other provision of law—

(1) *Waiver of criminal penalties.* In the case of a failure by a taxpayer to timely pay the shared responsibility payment, the taxpayer is not subject to criminal prosecution or penalty for the failure.

(2) *Limitations on liens and levies.* If a taxpayer fails to pay the shared responsibility payment imposed by this section and §§ 1.5000A–1 through 1.5000A–4, the Secretary will not file notice of lien on any property of the taxpayer, or levy on any property of the taxpayer for the failure.

(3) *Authority to offset against overpayment.* Nothing in this section prohibits the Secretary from offsetting any liability for the shared responsibility payment against any overpayment due the taxpayer, in accordance with section 6402(a) and its corresponding regulations.

(c) *Effective/applicability date.* This section and §§ 1.5000A–1 through 1.5000A–4 apply for months beginning after December 31, 2013.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

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

Authority: 26 U.S.C. 7805.

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

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB Control No.
* * * * *	
1.5000A–3	1545–0074
1.5000A–4	1545–0074
* * * * *	

Heather C. Maloy,

Acting Deputy Commissioner for Services and Enforcement.

Approved: August 26, 2013.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

[FR Doc. 2013–21157 Filed 8–27–13; 11:15 am]

BILLING CODE 4830–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0775]

Drawbridge Operation Regulations; Long Island, New York Inland Waterway From East Rockaway Inlet to Shinnecock Canal, NY

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, First Coast Guard District, has issued a temporary deviation from the regulation governing the operation of the Loop Parkway Bridge, mile 0.7, across Long Creek, and the Meadowbrook Parkway Bridge, mile 12.8, across Sloop Channel, both at Hempstead, New York. This deviation is necessary to facilitate the 2013 Dee Snider's Ride to Fight Hunger on Long Island. The deviation allows the two bridges to remain in the closed position during this public event.

DATES: This deviation is effective from 11 a.m. through 1 p.m. on September 8, 2013.

ADDRESSES: Documents mentioned in this preamble as being available in the docket are part of docket USCG–2013–0775 and are available online at *www.regulations.gov.* Type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this deviation. You may also visit the Docket Management Facility in Room W12–140, on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC, 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Ms. Judy Leung-Yee, Project Officer, First Coast Guard District, telephone (212) 668–7165, *judy.k.leung-yee@uscg.mil.* If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: The Loop Parkway Bridge, mile 0.7, across Long Creek has a vertical clearance in the closed position of 21 feet at mean high water and 25 feet at mean low water. The existing drawbridge operation regulations are listed at 33 CFR 117.799(f).

The Meadowbrook Parkway Bridge, mile 12.8, across Sloop Channel has a vertical clearance in the closed position of 22 feet at mean high water and 25 feet at mean low water. The existing drawbridge operation regulations are listed at 33 CFR 117.799(h). Long Creek and Sloop Channel are transited by commercial fishing and recreational vessel traffic.

The bridge owner for both bridges, the State of New York Department of Transportation, requested bridge closures to facilitate a public event, the 2013 Dee Snider's Ride to Fight Hunger.

Under this temporary deviation the Loop Parkway and the Meadowbrook Parkway Bridges may remain in the closed position between 11 a.m. and 1 p.m. on September 8, 2013, to facilitate a public event, the 2013 Dee Snider's Ride.

There are no alternate routes for vessel traffic; however, vessels that can pass under the closed draws during this closure may do so at any time. The bridges may be opened in the event of an emergency. The Coast Guard will inform the users of the waterways through our Local and/or Broadcast Notices to Mariners of the change in operating schedule for the bridges so that vessels can arrange their transits to minimize any impact caused by the temporary deviation.

In accordance with 33 CFR 117.35(e), the bridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.