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By the Commission.

Dated: September 19, 2022.

Vanessa A. Countryman,
Secretary.

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[TD 9968]

RIN 1545-BQ16

Affordability of Employer Coverage for Family Members of Employees

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations under section 36B of the Internal Revenue Code (Code) that amend the regulations regarding eligibility for the premium tax credit (PTC) to provide that affordability of employer-sponsored minimum essential coverage (employer coverage) for family members of an employee is determined based on the employee's share of the cost of covering the employee and those family members, not the cost of covering only the employee. The final regulations also add a minimum value rule for family members of employees based on the benefits provided to the family members. The final regulations affect taxpayers who enroll, or enroll a family member, in individual health insurance coverage through a Health Insurance Exchange (Exchange) and who may be allowed a PTC for the coverage.

DATES: These final regulations are effective on December 12, 2022.

FOR FURTHER INFORMATION CONTACT: Clara Raymond at (202) 317-4718 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

I. Overview

This document amends the Income Tax Regulations (26 CFR part 1) under section 36B of the Code. On April 7, 2022, the Department of the Treasury (Treasury Department) and the IRS published a notice of proposed rulemaking (REG-114339-21) in the **Federal Register** (87 FR 20354) under section 36B (proposed regulations). A public hearing was held on June 27, 2022. The Treasury Department and the IRS also received written comments on the proposed regulations. After consideration of the testimony heard at the public hearing and the comments received, the proposed regulations are adopted as amended by this Treasury decision (final regulations).

These final regulations provide that, for purposes of determining eligibility for PTC, affordability of employer coverage for individuals eligible to enroll in the coverage because of their relationship to an employee of the employer (related individuals) is determined based on the employee's share of the cost of covering the employee and the related individuals. As further explained in the Summary of Comments and Explanation of Revisions, the affordability rule for related individuals in these final regulations represents the better reading of the relevant statutes and is consistent with Congress's purpose in the Affordable Care Act (ACA)¹ to expand access to affordable health care coverage. The final regulations also include amendments to the rules relating to the determination of whether employer coverage provides a minimum level of benefits, referred to as minimum value; conforming amendments to the current regulations; and clarification of the treatment of premium refunds.

II. Eligibility for Employer Coverage Under Section 36B

Section 36B provides a PTC for applicable taxpayers who meet certain eligibility requirements, including that a member of the taxpayer's family enrolls in a qualified health plan through an Exchange (QHP or Exchange coverage) for one or more "coverage months." Under § 1.36B-1(d) of the Income Tax Regulations, a taxpayer's family consists of the taxpayer, the taxpayer's spouse if filing jointly, and any dependents of the taxpayer.

¹ The term ACA in this preamble means the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010).

Section 1.36B-3(d)(1) provides that the PTC for a coverage month is the lesser of: (i) the premiums for the month, reduced by any amounts that were refunded, for one or more QHPs in which a taxpayer or a member of the taxpayer's family enrolls (enrollment premiums); or (ii) the excess of the adjusted monthly premium for the applicable benchmark plan over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year (taxpayer's contribution amount).

Under section 36B(c)(2)(B) and § 1.36B-3(c), a month is a coverage month for an individual only if the individual is not eligible for minimum essential coverage (MEC) for that full calendar month (other than coverage under a health care plan offered in the individual market within a state). Under section 5000A(f)(1)(B) of the Code, the term MEC includes employer coverage. If an individual is eligible for employer coverage for a given month, no PTC is allowed for the individual for that month.

Section 36B(c)(2)(C) generally provides that an individual is not treated as eligible for employer coverage if the coverage offered is unaffordable or does not provide minimum value. However, if the individual enrolls in employer coverage, the individual is eligible for MEC, irrespective of whether the employer coverage is affordable or provides minimum value. See section 36B(c)(2)(C)(iii) and § 1.36B-2(c)(3)(vii).

Under the affordability test in section 36B(c)(2)(C)(i)(II), an employee who does not enroll in employer coverage is not treated as eligible for the coverage if "the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income."² The flush language following this provision provides that "[t]his clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee."

Section 5000A generally requires applicable individuals³ to make an individual shared responsibility payment⁴ with their tax return if they

² This required contribution percentage of 9.5 is indexed annually under section 36B(c)(2)(C)(iv). For simplicity, this preamble refers to 9.5 percent as the required contribution percentage.

³ Section 5000A(d)(1) defines an applicable individual as any individual other than an individual with a religious conscience exemption, an individual who is not lawfully present or an individual who is incarcerated.

⁴ Public Law 115-97 (2017), commonly referred to as the Tax Cuts and Jobs Act, reduced the

Continued

do not maintain minimum essential coverage for themselves and any dependents. Section 5000A(e)(1) establishes exemptions from the individual shared responsibility payment that would otherwise apply for “individuals who cannot afford coverage,” which the statute defines in section 5000A(e)(1)(A) to be applicable individuals whose required contribution for coverage exceeds a specified percentage of their household income. Section 5000A(e)(1)(B)(i) provides that, for an employee eligible to purchase employer coverage, the term “required contribution” means “the portion of the annual premium which would be paid by the individual . . . for self-only coverage.” For related individuals, the definition of “required contribution” in section 5000A(e)(1)(B)(i) is modified by a “special rule” in section 5000A(e)(1)(C). Section 5000A(e)(1)(C) provides that “[f]or purposes of [section 5000A(e)(1)](B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination [of affordability] under subparagraph (A) shall be made by reference to [the] required contribution of the employee.” The regulations under section 5000A interpret section 5000A(e)(1)(C) as modifying the required contribution rule in section 5000A(e)(1)(B)(i) regarding coverage for related individuals to take into account the cost of covering the employee and the related individuals, not just the employee. Specifically, for related individuals, § 1.5000A–3(e)(3)(ii)(B) provides that the required contribution is the amount an employee must pay to cover the employee and the related individuals who are included in the employee’s family.⁵ Thus, under § 1.5000A–3(e)(3)(ii)(B), employer coverage is affordable for those related individuals if the share of the annual premium the employee must pay to cover the employee and the related individuals is not greater than the required contribution percentage of household income.

In contrast to the affordability rule for related individuals in § 1.5000A–3(e)(3)(ii)(B), the Treasury Department and the IRS issued final regulations in 2013 for purposes of the PTC providing that employer coverage is affordable for the related individuals if the share of the annual premium the employee must

⁵ For purposes of this exemption for unaffordable coverage, an employee or related individual who is otherwise exempt under § 1.5000A–3 is not included in determining the required contribution.

pay for self-only coverage is not greater than the required contribution percentage of household income, regardless of how expensive the annual premium for family coverage would be. See § 1.36B–2(c)(3)(v)(A)(2) (the 2013 regulations or 2013 affordability rule). Thus, under the 2013 affordability rule, the employee’s share of the premium for family coverage, as defined in § 1.36B–1(m),⁶ was not considered in determining whether employer coverage is affordable for related individuals.

When the 2013 regulations were issued, the Treasury Department and the IRS considered the statutory language of section 36B(c)(2)(C)(i)(II) and its cross-reference to section 5000A(e)(1)(B), as well as the statutory language of section 5000A(e)(1)(B) and the cross-reference in section 5000A(e)(1)(C) to section 5000A(e)(1)(B). In the preamble to those regulations, the Treasury Department and the IRS interpreted the language of section 36B, through the cross-reference to section 5000A(e)(1)(B), to provide that the affordability test for related individuals is based on the cost of self-only coverage. Thus, if the cost of self-only coverage is affordable, no PTC is allowed for the Exchange coverage of related individuals even if family coverage through the employer costs more than 9.5 percent of household income.

As noted above, section 36B(c)(2)(C) generally provides that an individual is not treated as eligible for employer coverage if the coverage offered is unaffordable or does not provide minimum value. An eligible employer-sponsored plan provides minimum value under section 36B(c)(2)(C)(ii) and § 1.36B–6(a)(1) only if the plan’s share of the total allowed costs of benefits provided to an employee is at least 60 percent. On November 4, 2014, the IRS released Notice 2014–69, 2014–48 I.R.B. 903, which advised employers of the intent to propose regulations providing that group health plans that fail to provide substantial coverage for inpatient hospitalization or physician services do not provide minimum value. Notice 2014–69 noted that the Department of Health and Human Services (HHS) was concurrently issuing parallel guidance and also provided that, pending issuance of final Treasury regulations, an employee would not be required to treat a non-hospital/non-physician services plan as providing minimum value for purposes of an employee’s eligibility for a PTC.

On November 26, 2014, HHS issued proposed regulations providing that an eligible employer-sponsored plan provides minimum value only if, in addition to covering at least 60 percent of the total allowed costs of benefits provided under the plan, the plan benefits include substantial coverage of inpatient hospital services and physician services. See 79 FR 70674. On February 27, 2015, HHS finalized this minimum value rule at 45 CFR 156.145(a). See 80 FR 10750, 10872. On September 1, 2015, the Treasury Department and the IRS issued proposed regulations under section 36B (REG–143800–14, 80 FR 52678) (2015 proposed regulations) to incorporate the substance of the HHS final regulations regarding the minimum value rule. The 2015 proposed regulations issued by the Treasury Department and the IRS relating to substantial coverage of inpatient hospital services and physician services have not been finalized.

III. E.O. 14009

On January 28, 2021, President Biden issued Executive Order (E.O.) 14009, Strengthening Medicaid and the Affordable Care Act (ACA). Section 3(a) of E.O. 14009 directed the Secretary of the Treasury to review, as soon as practicable, all existing regulations and other agency actions to determine whether the actions are inconsistent with the policy to protect and strengthen the ACA and, as part of this review, to examine policies or practices that may reduce the affordability of coverage or financial assistance for coverage, including for dependents. Consistent with the E.O., the Treasury Department and the IRS reviewed the regulations under section 36B, including § 1.36B–2(c)(3)(v)(A)(2).

IV. Proposed Regulations

On April 7, 2022, the Treasury Department and the IRS published proposed regulations proposing to amend § 1.36B–2(c)(3)(v)(A)(2) to change the rule regarding the affordability of employer coverage for related individuals. The proposed regulations provided that, for purposes of determining eligibility for PTC, affordability of employer coverage for related individuals in the employee’s family would be determined based on the cost of covering the employee and those related individuals—just as affordability is determined in the regulations implementing section 5000A. For this purpose, affordability for related individuals would be based on the portion of the annual premium the employee must pay for coverage of

⁶ Section 1.36B–1(m) defines family coverage as health insurance that covers more than one individual and provides coverage for the essential health benefits as defined in section 1302(b)(1) of the ACA.

the employee and all other individuals included in the employee's family, within the meaning of § 1.36B-1(d), who are offered the coverage. Although some individuals who are not part of the family might be offered the employer coverage through the employee, the cost of covering individuals not in the family would not be considered in determining whether the related individuals in the employee's family have an offer of affordable employer coverage.

The proposed regulations would not change the affordability rule for employees. As required by statute, employees have an offer of affordable employer coverage if the employee's required contribution for self-only coverage of the employee does not exceed the required contribution percentage of household income.

The proposed regulations also addressed the minimum value rules in section 36B. Under the proposed regulations, a separate minimum value rule would be provided for related individuals that is based on the level of coverage provided to related individuals under an eligible employer-sponsored plan. In addition, the proposed regulations withdrew the 2015 proposed regulations and re-proposed the rule regarding substantial coverage of inpatient hospitalization services and physician services. Thus, under the proposed regulations, an eligible employer-sponsored plan would provide minimum value only if the plan covers at least 60 percent of the total allowed costs of benefits provided to an employee under the plan and the plan benefits include substantial coverage of inpatient hospital services and physician services.

Finally, the proposed regulations would amend § 1.36B-3(d)(1)(i) to clarify that, in computing the PTC for a coverage month, a taxpayer's enrollment premiums for the month are the premiums for the month, reduced by any amounts that were refunded in the same taxable year the taxpayer incurred the premium liability.

Summary of Comments and Explanation of Revisions

I. Overview

The Treasury Department and the IRS received 3,888 comments on the proposed regulations, the overwhelming majority of which were in support of the rules in the proposed regulations, including the affordability test for related individuals that is based on the cost of family coverage offered to the related individuals. Many commenters recounted personal stories of family members being uninsured due to the

unaffordability of family coverage offered by an employer and the unavailability of a PTC for Exchange coverage. One married couple even testified to a state legislature that they divorced solely to retain the husband's eligibility for the PTC after his wife got a new job with an offer of family coverage at a cost of \$16,000, over half of the husband's annual earnings.⁷ Some commenters made the point that an affordability test for related individuals that is based on the cost of the coverage offered to the employee and related individuals is family-friendly because it is more likely to provide all family members with access to affordable coverage. Many commenters agreed with the analysis in the preamble to the proposed regulations that the language of section 36B(c)(2)(C)(i) is best interpreted to require a separate affordability determination for related individuals that is based on the employee's cost to cover the employee and related individuals rather than a single affordability determination for both employees and related individuals that is based on the cost of self-only coverage to employees, and provided persuasive legal support for this position. Commenters also overwhelmingly supported the minimum value rules provided in the proposed regulations and agreed that a failure to provide a separate minimum value rule for related individuals could undermine the separate affordability rule for related individuals.

Other commenters expressed the view that the separate affordability test and minimum value rule for related individuals in the proposed regulations are contrary to the language of section 36B, and that the Treasury Department and the IRS do not have the authority to change those rules. Several of these commenters provided legal analyses in support of their position as well as policy arguments against the proposed affordability test and minimum value rule for related individuals. For reasons explained in sections II and III of this Summary of Comments and Explanation of Revisions, the Treasury Department and the IRS are not persuaded by these arguments.

Some commenters suggested that the Treasury Department and the IRS adopt various changes to the rules in the proposed regulations. Other commenters requested outreach by HHS, the Treasury Department, and the IRS to educate individuals, employers, and other stakeholders about the final

regulations once they are issued. Several commenters requested clarification on certain issues related to employers, including information reporting requirements under section 6056 of the Code and the effect of the final regulations on individuals enrolled in non-calendar year plans. These comments are addressed in sections IV, V, and VI of the Summary of Comments and Explanation of Revisions.

Finally, many commenters supported the minimum value rule in the proposed regulations under which an eligible employer-sponsored plan would provide minimum value to an employee only if, in addition to covering at least 60 percent of the total allowed costs of benefits provided to an employee under the plan, the plan's benefits include substantial coverage of inpatient hospitalization services and physician services. In addition, many commenters supported the proposed amendment to § 1.36B-3(d)(1)(i) to clarify that, in computing the PTC for a coverage month, a taxpayer's enrollment premiums for the month are the premiums for the month, reduced by any amounts that were refunded in the same taxable year the taxpayer incurred the premium liability. Because commenters supported these rules and did not request any modifications to them, both the proposed minimum value rule for employees related to inpatient hospitalization services and physician services and the proposed clarification of the premium refund rule are being finalized without change.

II. Comments on Legal Analysis

A. Statutory Analysis of Affordability Rule

Under section 36B(c)(2)(C)(i)(II), an employee who does not enroll in employer coverage is not considered eligible for the coverage if "the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income." The flush language following this provision provides that "[t]his clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee."

As discussed in the preamble to the proposed regulations, the flush language in section 36B(c)(2)(C)(i) does not state clearly and expressly how section 36B(c)(2)(C)(i)(II) applies to related individuals or how the cross-reference to section 5000A(e)(1)(B) applies to coverage for related individuals. Section 5000A(e)(1)(B)(i) provides that, for an

⁷ See <https://legislature.maine.gov/legis/bills/getTestimonyDoc.asp?id=161949>.

employee eligible to purchase employer coverage, the term “required contribution” means “the portion of the annual premium which would be paid by the individual . . . for self-only coverage.” For related individuals, the definition of “required contribution” in section 5000A(e)(1)(B)(i) is modified by a “special rule” in section 5000A(e)(1)(C). Section 5000A(e)(1)(C) provides that “[f]or purposes of [section 5000A(e)(1)(B)(i)], if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under [section 5000A(e)(1)(A)] shall be made by reference to [the] required contribution of the employee.” The regulations under section 5000A interpret section 5000A(e)(1)(C) as modifying the required contribution rule in section 5000A(e)(1)(B)(i) for coverage for a related individual to provide that the determination under section 5000A(e)(1)(A) is made by reference to the required contribution of the employee for coverage for the employee and that related individual. Specifically, for related individuals, § 1.5000A–3(e)(3)(ii)(B) provides that the required contribution for related individuals is the amount an employee must pay to cover the employee and all related individuals who are included in the employee’s family.⁸ This long-standing rule under section 5000A was proposed in February 2013⁹ and did not generate any critical comments. The proposed rule was finalized without change in August 2013¹⁰ and has never been challenged.

Similar to the regulations implementing section 5000A, the proposed regulations provided an affordability rule for related individuals for section 36B purposes that looks to the cost of coverage for the employee and related individuals and is separate from the affordability rule for employees of the employer offering the coverage. Under the proposed regulations, affordability for related individuals would be based on the portion of the annual premium the employee must pay for coverage of the employee and all other individuals included in the employee’s family, within the meaning of § 1.36B–1(d), who are offered the coverage.

Some commenters expressed the view that the affordability rule in the proposed regulations conflicts with the

language in section 36B, that the 2013 affordability rule is correct, and that the affordability rule for related individuals in the proposed regulations should be withdrawn. These commenters argued that section 36B unambiguously establishes a single affordability test for both employees and related individuals that is based on the cost of self-only coverage to the employee. As explained later in this section II.A. of the Summary of Comments and Explanation of Revisions, however, the proposed rule’s approach represents the better reading of the statute and the better means of implementing it. After careful consideration, the Treasury Department and the IRS are adopting the affordability test as proposed. The Treasury Department and the IRS are of the view that section 36B(c)(2)(C)(i), including the flush language that follows section 36B(c)(2)(C)(i)(II), is correctly interpreted to provide that the affordability test for a related individual is based on the cost of coverage for the employee and the related individual. The flush language provides as follows: “[t]his clause shall also apply to a [related individual].” Thus, taking into account the flush language, section 36B(c)(2)(C)(i) may be read to apply to a related individual as follows:

[A related individual] shall not be treated as eligible for minimum essential coverage if such coverage (I) consists of an eligible employer-sponsored plan [], and (II) the employee’s¹¹ required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer’s household income.

This language includes four references to the coverage provided by the employee’s employer: “minimum essential coverage,” “such coverage,” “eligible employer-sponsored plan,” and “the plan.” Without question, “such coverage” refers to the minimum essential coverage offered by the employee’s employer to the related individual, as do references to “employer-sponsored plan” and “the plan.” Unless a related individual is also employed by that employer, the related individual may not enroll in the employer’s coverage on a self-only basis. Thus, the minimum essential coverage referred to in section 36B(c)(2)(C)(i), as it applies to related individuals, is the coverage the related individual may enroll in, which is the family coverage offered by the employer. Under this

reading, the reference to “the employee’s required contribution . . . with respect to the plan” is the required contribution for family coverage.

This reading gives full effect to section 36B(c)(2)(C)(i)(II)’s cross reference to section 5000A(e)(1)(B). As noted earlier in this section II.A. of the Summary of Comments and Explanation of Revisions, section 36B(c)(2)(C)(i) specifies rules to determine the affordability of coverage under an eligible employer-sponsored plan both for an employee and for related individuals. Taken in isolation, section 5000A(e)(1)(B) would specify a rule for determining the affordability of a required contribution only with respect to coverage for an employee, even though the flush language in section 36B(c)(2)(C)(i) requires a calculation to be performed for related individuals as well. Section 5000A(e)(1)(C) provides a rule for that calculation by specifying a “special rule” for purposes of the calculation of the employee’s required contribution for coverage that includes the related individual. As explained earlier in this section II.A. of the Summary of Comments and Explanation of Revisions, the Treasury Department and the IRS have long understood section 5000A(e)(1)(C) in this way. See § 1.5000A–3(e)(3)(ii)(B), promulgated in 2013.

As noted in section I of this Summary of Comments and Explanation of Revisions, the vast majority of commenters supported the proposed affordability rule for related individuals, and several of these commenters provided detailed technical analyses in support of this interpretation of the statute. Some of those commenters argued that section 36B unambiguously establishes a separate affordability test for related individuals that is based on the cost of family coverage. For example, one commenter asserted that the proposed affordability rule for related individuals follows the plain language of the statute and that section 5000A(c)(1)(C) states on its face that it must be read into 5000A(c)(1)(B). Another commenter argued that the plain text of the statute indicates that a related individual’s eligibility for the PTC is based on the cost of family coverage and that the affordability rule in the 2013 regulations reflected a strained reading of the statute. One commenter supported the proposed affordability rule for related individuals but disagreed that the rule adopts an “alternative” reading of the statute. Instead, the commenter opined that the interpretation in the proposed regulations is correct and that the affordability rule in the 2013 regulations

⁸ For purposes of this exemption for unaffordable coverage, an employee or related individual who is otherwise exempt under § 1.5000A–3 is not included in determining the required contribution.

⁹ REG–148500–12 (78 FR 7314).

¹⁰ TD 9632 (78 FR 53646).

¹¹ The term “employee” would not be replaced with “related individual” here because it is the employee who makes contributions (through salary reduction or otherwise) to pay for employer coverage, even if the employer coverage includes family members of the employee.

reflected an erroneous interpretation of the ACA. Finally, one commenter stated that the 2013 regulations implementing section 36B badly misinterpret the statute and that section 36B mandates a family-based affordability test. The commenter noted that if Congress had intended a self-only test, it would have mandated that coverage be deemed affordable for a related family member so long as the employee can afford self-only coverage, rather than obliquely stating that the special rule applies to related family members as well.

For reasons explained in section III of this Summary of Comments and Explanation of Revisions, the Treasury Department and the IRS have concluded that the affordability rule for related individuals in the proposed regulations, as finalized in these regulations, is the better reading of the statute and the better means of implementing the statute. Further, the Treasury Department and the IRS believe that the affordability rule in these final regulations is consistent with the goal of the ACA to provide access to affordable, quality health care for all Americans.¹² Indeed, under the 2013 regulations, some family members of employees could not access any PTC for Exchange coverage even if their only offer of employer coverage was a family plan with exorbitant premiums (about 16% of income, on average),¹³ solely because the employee had access to affordable self-only coverage.

As explained earlier in this section II.A of the Summary of Comments and Explanation of Revisions, the Treasury Department and the IRS disagree with commenters who argued that section 36B unambiguously establishes a single affordability test for both employees and related individuals that is based on the cost of self-only coverage to the employee. Some of these commenters argued that, because section 36B(c)(2)(C)(i)(II) does not cross-reference section 5000A(e)(1)(C) in defining the term “required contribution,” section 5000A(e)(1)(C) cannot be considered in determining whether a related individual has been offered affordable employer coverage for purposes of section 36B. One of those commenters also argued that, under the negative-implication canon of statutory interpretation,¹⁴ the reference to section 5000A(e)(1)(A) in section 5000A(e)(1)(C) precludes the use of the rule in section

5000A(e)(1)(C) for other purposes, such as providing a rationale for an affordability test in section 36B for related individuals that is separate from the test for employees.

The Treasury Department and the IRS disagree. As noted in the Background section and earlier in this section II.A. of the Summary of Comments and Explanation of Revisions, the definition of “required contribution” in section 5000A(e)(1)(B)(i) is modified by a “special rule” in section 5000A(e)(1)(C) that is applicable to related individuals. Section 5000A(e)(1)(C) provides that “[f]or purposes of [section 5000A(e)(1)(B)(i)], if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to [the] required contribution of the employee.” The regulations under section 5000A interpret section 5000A(e)(1)(C) as modifying the required contribution rule in section 5000A(e)(1)(B)(i) regarding coverage for related individuals to take into account the cost of covering the employee and the related individuals, not just the employee. Specifically, § 1.5000A–3(e)(3)(ii)(B) provides that the required contribution for related individuals is the amount an employee must pay to cover the employee and the related individuals who are included in the employee’s family.¹⁵ Because section 5000A(e)(1)(C) begins with the language “[f]or purposes of [section 5000A(e)(1)(B)(i)],” the parenthetical cross reference in section 36B(c)(2)(C)(i)(II) to section 5000A(e)(1)(B)(i) incorporates the special rule in section 5000A(e)(1)(C) and modifies section 5000A(e)(1)(B)(i) when the coverage in question is for related individuals. Accordingly, a specific reference to section 5000A(e)(1)(C) in the flush language of section 36B(c)(2)(C)(i) is not necessary to require the consideration of section 5000A(e)(1)(C) for determining whether coverage offered to related individuals is affordable under section 36B.

In addition, the Treasury Department and the IRS disagree that the negative-implication canon of statutory construction compels the conclusion that the reference to section 5000A(e)(1)(A) in section 5000A(e)(1)(C) precludes the use of the rule in section 5000A(e)(1)(C) for section 36B purposes. As the Supreme Court has emphasized

in numerous cases, the force of any negative implication depends on the context, and the negative-implication canon applies only when circumstances support a sensible inference that the term left out must have been meant to be excluded. See, for example, *Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73, 81 (2002) (“The [negative-implication canon] is fine when it applies, but this case joins some others in showing when it does not.”); *United States v. Vonn*, 535 U.S. 55, 65 (2002) (“At best, as we have said before, the [negative-implication canon] is only a guide, whose fallibility can be shown by contrary indications that adopting a particular rule or statute was probably not meant to signal any exclusion of its common relatives”); *United Dominion Industries v. United States*, 532 U.S. 822, 836 (2001) (“But here, as always, the soundness of the [negative-implication canon] is a function of timing”).¹⁶ See also Antonin Scalia & Bryan Garner, *Reading Law: The Interpretation of Legal Texts* 107 (2012), stating that the negative-implication canon “must be applied with great caution since its application depends so much on context.” Here, the context points in favor of not restricting the use of section 5000A(e)(1)(C) to the determination in 5000A(e)(1)(A). Instead, the context points in favor of reading the reference in section 36B(c)(2)(C)(i) to section 5000A(e)(1)(B) as incorporating the modification of that subparagraph in section 5000A(e)(1)(C). This reading creates a clear and consistent rule for determining the affordability of coverage for related individuals for purposes of both section 36B and section 5000A. And, as explained earlier in this section II.A. of the Summary of Comments and

¹² See H.R. Rep. No. 111–443 (2009).

¹³ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1491>.

¹⁴ The negative-implication canon of construction—*expressio unius est exclusio alterius*—means the expression of one thing implies the exclusion of the other.

¹⁵ For purposes of this exemption for unaffordable coverage, an employee or related individual who is otherwise exempt under § 1.5000A–3 is not included in determining the required contribution.

¹⁶ Notably, in *U.S. Venture, Inc. v. United States*, 2 F.4th 1034 (7th Cir. 2021), the court rejected an argument by a taxpayer that the negative-implication canon of statutory interpretation required an outcome consistent with the taxpayer’s interpretation of a provision of the Internal Revenue Code. The question considered by the court was whether a taxpayer’s sale of a butane and gasoline mix qualified for the alternative fuel mixture credit in section 6426 of the Code. In discussing whether the sale of the butane and gasoline mix should qualify for the credit, the court rejected the taxpayer’s argument that a specific cross reference in section 6426(e) to section 4083(a)(2) for the definition of a term in section 6426(e) forecloses using a third provision, section 4083(a)(2), to further illuminate the definition in section 4083(a)(1). The court “decline[d]” the taxpayer’s invitation “to follow a congressionally mandated cross-reference only part of the way. Instead, we must accept and follow the cross-referenced definition in full.” *U.S. Venture, Inc.*, 2 F.4th at 1042. “Whether the cross-reference is to the individual sub-paragraphs or to the whole statute does not change the meaning that Congress chose to give ‘gasoline’ in § 4083 and, consequently, in § 6426(e).” *Id.*

Explanation of Revisions, without incorporating section 5000A(e)(1)(C), the statute would point only to a calculation of affordability for the employee's coverage, even though section 36B requires a calculation of affordability for the related individuals as well.

Moreover, had Congress intended section 5000A(e)(1)(C) to apply only to the affordability determination under section 5000A, excluding all other provisions, it could have done so through explicit means, such as using the language "solely for purposes of the determination under section 5000A(e)(1)(A)." See, for example, section 4980H(c)(2)(D) and section 4980H(c)(2)(E), also enacted under the ACA and which provide "solely for purposes of" limiting language. No such limiting language is included in section 5000A(e)(1)(C). More generally, had Congress intended a self-only affordability test for related individuals, it could have explicitly provided that coverage is affordable for a related individual so long as the employee is offered affordable self-only coverage. Congress did just that in 2016 when it enacted section 36B(c)(4), relating to the affordability of employer coverage under a qualified small employer health reimbursement arrangement (QSEHRA).

Under section 36B(c)(4)(A), a PTC is not allowed for a month for the Exchange coverage of "an employee (or any spouse or dependent of such employee) if for such month the employee is provided a [QSEHRA] which constitutes affordable coverage." A QSEHRA is affordable for a month if the excess of (1) the monthly premium for the second lowest cost silver plan for self-only coverage of the employee offered in the Exchange for the rating area in which the employee resides, over (2) 1/12 of the employee's permitted benefit (as defined in section 9831(d)(3)(C)) under the QSEHRA, does not exceed 1/12 of 9.5 percent of the employee's household income.

In contrast to the language in section 36B(c)(2)(C)(i)(II), section 36B(c)(4)(A) does not reference section 5000A(e)(1)(B) for the QSEHRA affordability determination or provide that "this clause shall also apply" to a related individual. Instead, it provides the same affordability rule for both employees and related individuals by stating that affordability for coverage under a QSEHRA for "an employee (or any spouse or dependent of such employee)" is based on the cost of self-only coverage of the employee. That is far different from the language in section 36B(c)(2)(C)(i)(II) and, therefore, it is reasonable to conclude that the

affordability rule in section 36B(c)(2)(C)(i)(II) for related individuals is not the same as the affordability rule for related individuals in section 36B(c)(4)(A).

Additionally, the structure and context of sections 36B and 5000A suggest that Congress did not intend to preclude the use of section 5000A(e)(1)(C) in determining the affordability of employer coverage for related individuals for purposes of PTC eligibility under section 36B. Foremost, when the coverage in question is for related individuals, section 36B(c)(2)(C)(i)(II) specifically refers to the definition of required contribution in section 5000A(e)(1)(B)(i), and section 5000A in turn specifically incorporates the special rule in section 5000A(e)(1)(C) "for purposes of" section 5000A(e)(1)(B)(i). Under this statutory structure, a specific reference to section 5000A(e)(1)(C) in the flush language of section 36B(c)(2)(C)(i) is not necessary to require the consideration of section 5000A(e)(1)(C) in determining affordability for related individuals for section 36B purposes. This consideration of section 5000A(e)(1)(C) is particularly sensible given the flush language in section 36B(c)(2)(C)(i)(II). That is, the flush language evinces Congress's intent to provide an affordability rule for related individuals. Given that there are numerous cross references in section 36B to section 5000A and that section 5000A confronts a similar situation relating to affordability for related individuals that is resolved through section 5000A(e)(1)(C), it is logical to consider section 5000A(e)(1)(C) for purposes of the affordability rule for related individuals under section 36B. Finally, using the rule in section 5000A(e)(1)(C) in determining the affordability of employer coverage for related individuals for section 36B purposes supports the goal of the ACA to provide affordable, quality health care for all Americans. See H.R. Rep. No. 111-443 (2009).

B. Consistency Between the Affordability Rules of Sections 36B and 5000A

The preamble to the proposed regulations noted that the proposed affordability rule under section 36B would create greater consistency between the section 36B affordability rules and the rules in section 5000A used to determine whether an individual is exempt from the individual shared responsibility payment under section 5000A because employer coverage is unaffordable. With the finalization of the proposed section

36B affordability rule in these final regulations, both rules provide that affordability for employees is based on the employee's cost for self-only coverage and that affordability for family members is generally based on the amount an employee must pay to cover the employee and the related individuals included in the employee's family. Thus, these final regulations promote consistency between these two affordability rules.

One commenter argued that Congress did not intend the affordability rules of section 36B and section 5000A to be consistent, suggesting that it instead sought to make it easier for a taxpayer to avoid a section 5000A individual shared responsibility payment for a related individual than to qualify for a PTC for such individual. In other words, the commenter seems to be suggesting that Congress's intent was to make it easier to go without health insurance coverage than to qualify for subsidized Exchange coverage. However, the commenter does not point to any evidence of this beyond the assertion that the statutory text compels this result. As explained above, the Treasury Department and the IRS disagree with the commenter's reading of the statutory text. The commenter's argument also ignores Congress's broader goal of expanding access to affordable health insurance coverage through the ACA, which goal is advanced by the affordability rule for related individuals in these final regulations.

C. Legislative History of ACA

One commenter also argued that the legislative history underlying the ACA shows that Congress intended that the rule for affordability of employer coverage for family members be the same as the affordability rule for employees and that both determinations are intended to be based on the cost of self-only coverage to the employee. The argument is that S. 1796, the America's Healthy Future Act of 2009¹⁷ (one of the Senate bills that became the ACA through consolidation with another bill¹⁸ and amendment), as introduced, based the determination of the affordability of employer-sponsored coverage on the employee's required contribution, as defined by (what was in that version of the bill) section 5000A(e)(2), which would have set affordability tests for both self-only and family coverage.

The commenter further argued that, when the bill that became the ACA was introduced on the Senate floor, it altered

¹⁷ 111th Congress (2009).

¹⁸ H.R. 3590, 111th Congress (2009).

the language of S. 1796 to reflect the language currently in the statute, in which the required contribution is described as “within the meaning of section 5000A(e)(1)(B).” In the commenter’s view, this change demonstrates that the required contribution rule in section 5000A(e)(1)(C) does not apply to the section 36B affordability test for related individuals. The commenter asserted that the proposed regulations fail to consider the changes to S. 1796 because the affordability test under the proposed regulations reflects exactly how the required contribution for related individuals would have been determined had these changes not been made.

The Treasury Department and the IRS disagree that the change in legislative language on the Senate floor described by the commenter indicates that Congress intended that affordability for related individuals must be based on the cost of self-only coverage to the employee. At the same time that the legislative sponsors added the language to section 36B that cross-references section 5000A(e)(1)(B), they also added the introductory phrase to section 5000A(e)(1)(C) clarifying that that subparagraph applies “for purposes of” subparagraph (e)(1)(B). The fact that the legislative sponsors made both of these changes at the same time indicates that they understood that section 36B would incorporate both subparagraphs into its affordability rule. Moreover, as noted by a number of commenters supportive of the proposed regulations, had Congress intended an identical affordability rule for employees and related individuals, the flush language in section 36B(c)(2)(C)(i) would not have been necessary. For example, Congress could simply have stated that affordability for an employee (or any spouse or dependent of such employee) is based on the cost of self-only coverage of the employee. Indeed, as explained in section II.A. of this Summary of Comments and Explanation of Revisions, Congress did exactly that when it enacted the affordability rules for QSEHRAs in section 36B(c)(2)(4). That, however, is not the direction that Congress chose to take with its changes to S. 1796. Instead, Congress enacted two rules, one for employees and one for related individuals. Consequently, it is reasonable to conclude that Congress’s use of separate rules for employees and related individuals indicates an intent to provide separate tests for an employee, based on the cost of self-only coverage to the employee, and for related individuals, based on the

cost of the coverage for the employee and those related individuals.

D. Legislative Proposals To Change Affordability Rule

Several commenters also argued that a change to the affordability rule for related individuals should be accomplished by legislative action, rather than regulatory action. They argued that, despite requests to amend section 36B to provide that affordability of employer coverage for related individuals is based on the employee’s cost for family coverage, Congress has not amended section 36B to specifically command this result. In addition, they noted that Congress has included language in various bills to amend the affordability rule, but the proposed legislation has not been enacted. The commenters asserted that this Congressional inaction means that the Treasury Department and the IRS are not empowered to issue regulations to address a matter that Congress acknowledges must be addressed in legislation.

Although the commenters are correct that members of Congress have included language in various bills to address the section 36B affordability rule in section 36B(c)(2)(C)(i), the introduction of proposed legislation is not an acknowledgement by Congress that the section 36B affordability test for related individuals must be addressed in legislation and not by regulation. As the Supreme Court has emphasized, “failed legislative proposals are a particularly dangerous ground on which to rest an interpretation of a prior statute [internal quotations omitted] Congressional inaction lacks persuasive significance because several equally tenable inferences may be drawn from that inaction, including the inference that the existing legislation already incorporated the offered change.” *Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 187 (1994) (quoting *Pension Benefit Guaranty Corporation v. LTV Corp.*, 496 U.S. 633, 650 (1990)). Here, for instance, it is possible that legislative proposals were introduced not because of insufficient language in the ACA, but because members of Congress believed that the 2013 regulations had incorrectly interpreted the existing language of the ACA. Although Congress may not have enacted legislation specifically and unequivocally mandating the approach taken in these final regulations, the Treasury Department and the IRS have determined that existing section 36B(c)(2)(C)(i) is better interpreted to require separate affordability

determinations for employees and for family members, as set forth in § 1.36B-2(c)(3)(v)(A)(2) of these final regulations.

E. Interpretation of Joint Committee on Taxation Report

In a footnote in the preamble to the proposed regulations, the Treasury Department and the IRS observed that in the Joint Committee on Taxation report, *Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as amended, in combination with the “Patient Protection and Affordable Care Act,”* (JCX-18-10), March 21, 2010 (JCT report), the staff of the Joint Committee on Taxation (Joint Committee staff) initially explained that “[u]naffordable is defined as coverage with a premium required to be paid by the employee that is 9.5 percent or more of the employee’s household income, based on the type of coverage applicable (e.g., individual or family coverage).” The Joint Committee staff later revised the quoted language, after the enactment of the ACA, to state that “[u]naffordable is defined as coverage with a premium required to be paid by the employee that is 9.5 percent or more of the employee’s household income, based on self-only coverage.” *ERRATA for JCX-18-10*, (JCX-27-10), May 4, 2010 (May 2010 Errata).

A few commenters expressed the view that the original JCT report was in error and should not be viewed as evidence that the statutory language in section 36B(c)(2)(C)(i)(II) supports a separate affordability rule based on the cost of family coverage; these commenters noted that the May 2010 Errata corrected the error. The Treasury Department and the IRS acknowledge that the Joint Committee staff characterized the May 2010 Errata as a correction of an error but disagree with the commenters as to the relevance of that observation. The May 2010 Errata was not before Congress at the time that the ACA was enacted in March 2010. In any event, neither the JCT report nor the May 2010 Errata is considered part of the legislative history, and neither is dispositive of any particular statutory interpretation.

F. Relevance of Section 18081

The preamble to the proposed regulations noted that the proposed regulations would promote consistency between the affordability rules in sections 36B and 5000A and the rule in 42 U.S.C. 18081(b)(4)(C) (section 18081(b)(4)(C)). Section 18081(b)(4)(C) relates to information that a QHP enrollee must provide as part of the enrollee’s QHP application if the

enrollee wants to be determined eligible for advance payments of the PTC (APTC) or cost-sharing reductions. Under section 18081(b)(4)(C), if an employer offers minimum essential coverage to an individual seeking to enroll in a QHP, and the individual asserts that the offer does not preclude the individual from qualifying for APTC or cost-sharing reductions because it is not affordable, the QHP applicant must provide to the Exchange information on “the lowest cost option for the enrollee’s or [related] individual’s enrollment status and the enrollee’s or [related] individual’s required contribution (within the meaning of section 5000A(e)(1)(B) of title 26) under the employer-sponsored plan.”

Certain commenters opined that they saw no inconsistency between the 2013 affordability rule under section 36B, the affordability rule under section 5000A, and the QHP applicant information rule in section 18081(b)(4)(C). One commenter stated that section 18081(b)(4)(C), by referencing section 5000A(e)(1)(B), merely instructs Exchanges to determine “the portion of the annual premium which would be paid by the individual . . . for self-only coverage” under the employer-sponsored plan. Another commenter argued that section 18081(b)(4)(C), by using the term “or” and not “and,” requires the submission of information on the required contribution solely for the employee who is offered employer coverage, meaning the individual who would pay the required contribution, but that the individual enrolling in the QHP could be the employee or someone related to the employee. This commenter further argued that in either case, the only information required by section 18081(b)(4)(C) is the lowest cost option for self-only coverage and the required contribution for the applicable employee.

The Treasury Department and the IRS agree with the commenter who noted that section 18081(b)(4)(C) requires the submission of information on the required contribution solely for the employee who is offered employer coverage and that the individual enrolling in the QHP could be the employee or someone related to the employee. However, the Treasury Department and the IRS disagree with the conclusion of both commenters that section 18081(b)(4)(C) requires Exchanges to collect information on only the portion of the annual premium that would be paid by the employee for self-only coverage under the employer-sponsored plan.

Section 18081 requires Exchanges to collect information from enrollees who

are offered coverage under an employer plan on “the lowest cost option” that the employee, whether the enrollee or an individual related to the enrollee, must contribute for the employee’s or individual’s enrollment status. The language “lowest cost option for the . . . enrollment status” indicates that the amount may vary depending on whether the employee’s enrollment status would be for self-only or family coverage. Otherwise, section 18081(b)(4)(C) would refer to “the lowest cost option for the enrollee for self-only coverage.” Thus, the Treasury Department and the IRS are of the view that the amendment to § 1.36B–2(c)(3)(v)(A)(2) in these final regulations and the similar affordability rule in § 1.5000A–3(e)(3)(ii)(B) are consistent with the QHP applicant information rule in section 18081(b)(4)(C).

G. Coordination With Section 4980H

One commenter asserted that the framework of section 4980H supports the view that a separate affordability test under section 36B for related individuals is not warranted. Section 4980H provides that an applicable large employer (ALE) generally must offer coverage to full-time employees and their dependents or potentially be subject to an employer shared responsibility payment. As the commenter noted, although ALEs are required to offer coverage to full-time employees and dependents, only the coverage offered to the full-time employees is required to be affordable. There is no comparable affordability rule for the coverage offered to dependents. In addition, an employer’s obligation to make a payment under section 4980H is triggered only when a full-time employee is allowed a PTC.

The commenter stated that the affordability of self-only coverage is the key determinant in whether an employer of a full-time employee must make a section 4980H payment and in whether the full-time employee and his or her dependents are allowed a PTC. The commenter argued that this framework shows Congress’s intent that section 36B and section 4980H have just one affordability test based on the cost of self-only coverage to the employee and that providing an affordability test for related individuals based on the cost of family coverage is not consistent with that framework.

The Treasury Department and the IRS disagree. Section 36B and section 4980H apply to different types of taxpayers and have different purposes. Section 36B provides a PTC to taxpayers and their families who meet certain requirements, one of which is that they are not eligible

for affordable, minimum value coverage from their employer. The amount of the PTC is determined based on family size and household income, among other factors, in recognition of the fact that affordability of coverage depends on the cost to the family. The PTC is integral to ensuring that individuals and their families can access affordable coverage through an Exchange. In contrast, section 4980H imposes a payment on ALEs if they fail to offer minimum essential coverage to their full-time employees and their dependents, and at least one full-time employee is allowed a PTC. Section 4980H does not require that employer coverage be offered to an employee’s spouse, and it does not require that any coverage offered to spouses or dependents be affordable. Further, employers do not owe a payment under section 4980H if a PTC is allowed for an employee’s spouse or dependent. The purpose of this provision is to ensure that large employers share responsibility under the ACA for providing affordable health coverage to employees, but this responsibility does not extend to affordable coverage for spouses or dependents. Given these differing purposes, there is nothing in this framework that suggests Congress intended for section 36B and section 4980H to have a single affordability test based on the cost of self-only coverage to the employee.

In addition, the goal of the ACA is to provide affordable, quality health care for all Americans,¹⁹ not just to full-time employees of ALEs, and these final regulations further that goal. In light of that goal, and contrary to the suggestion of the commenter, the lack of any requirement under section 4980H for ALEs to offer affordable coverage to family members of employees indicates that a PTC should be allowed for family members offered unaffordable coverage.

H. Minimum Value Rule

As noted in the Background section of this preamble, an employee generally is not treated as eligible for coverage under an eligible employer-sponsored plan unless the coverage provides minimum value, as defined in section 36B(c)(2)(C)(ii). Under section 36B(c)(2)(C)(ii) and § 1.36B–6(a)(1), an eligible employer-sponsored plan provides minimum value if the plan’s share of the total allowed costs of benefits provided to an employee is at least 60 percent, regardless of the total allowed costs of benefits.

The proposed regulations provided a minimum value rule for related

¹⁹ See H.R. Rep. No. 111–443 (2009).

individuals that is based on the plan's share of the total allowed cost of benefits provided to the related individuals. Under the proposed regulations, an eligible employer-sponsored plan satisfies the minimum value requirement for related individuals only if the plan's share of the total allowed costs of benefits provided to related individuals is at least 60 percent, similar to the existing rule in § 1.36B–6(a)(1) for employees.

The vast majority of commenters supported the separate minimum value rule for related individuals in the proposed regulations. However, two commenters stated that the minimum value requirement in section 36B applies only to employees and that the Treasury Department and the IRS have no authority to provide a minimum value rule for related individuals. In the view of these commenters, related individuals are eligible for employer coverage if the coverage is affordable, even if the plan's share of the total allowed costs of benefits provided to related individuals is below 60 percent. This approach, however, is contrary to the approach taken in current § 1.36B–2(c)(3)(i)(A), which was promulgated in final regulations in 2012. See TD 9590 (77 FR 30377). Section 1.36B–2(c)(3)(i)(A) clarifies that there is a minimum value requirement for both employees and related individuals, stating that “an employee who may enroll in an eligible employer-sponsored plan . . . that is minimum essential coverage, and an individual who may enroll in the plan because of a relationship to the employee (a related individual), are eligible for minimum essential coverage under the plan for any month only if the plan is affordable and provides minimum value.” Under this long-standing rule, a related individual who receives an offer of employer coverage that does not provide minimum value is deemed to be ineligible for the coverage, and a PTC may be allowed for the related individual provided that the related individual does not enroll in the coverage. The proposed regulations did not propose to revisit this long-standing rule.

Further, as stated in the preamble to the proposed regulations, without a separate minimum value rule for related individuals based on the costs of benefits provided to related individuals, a PTC would not be allowed for a related individual offered coverage under a plan that was affordable but provided minimum value only to employees and not to related individuals. This outcome would diminish the benefit a related individual

would derive from the amendment of the affordability rule for related individuals. That is, the affordability of employer coverage for related individuals would be based on the employee's cost of covering the related individuals, but there would be no assurance that the affordable coverage offered to the related individuals provided a minimum value of benefits to the related individuals.

Moreover, as described by commenters supportive of the minimum value rule for related individuals, it is extremely rare for an employer plan to provide a different level of coverage for family members than the coverage level provided to the employee enrolled in the plan. This is because most employers that offer multiple benefits packages offer family coverage on the condition that the employee and the employee's family must enroll in the same benefits package, which will then have the same minimum value for the entire family. Thus, if an employer plan offered to employees provides minimum value, and that plan is also offered to related individuals, the plan generally will also provide minimum value to the family members. Nevertheless, because the lack of a separate minimum value rule for related individuals would be inconsistent with the goals of the ACA in providing comprehensive health coverage and improving access to quality and affordable health care, the final regulations provide that an eligible employer-sponsored plan provides minimum value for related individuals only if the plan's share of the total allowed costs of benefits provided to related individuals is at least 60 percent and the plan benefits include substantial coverage of inpatient hospital services and physician services.

III. Rationale for Change

At the time that the Treasury Department and the IRS promulgated the 2013 regulations, limited information was available to model the effects of an affordability rule for related individuals based on the cost of family coverage. In the years since the 2013 regulations became effective in 2014, however, the Treasury Department and the IRS have learned more about how the ACA is affecting individuals, families, employers, group health plans, health insurance markets, and other stakeholders. For example, in 2017, the Congressional Budget Office (CBO) determined that 2010 reports by CBO and JCT on the budgetary effects of the ACA dramatically overstated the cost of

the PTC.²⁰ In the 2017 report, the CBO noted that, to a great extent, the differences arose because actual results deviated from the agencies' expectations about how the economy would change and how people and employers would respond to the law, and that, to a lesser extent, the differences were caused by judicial decisions, statutory changes, and administrative actions that followed the ACA's enactment.

Despite the initial uncertainty about the ACA's effects, there has been substantial progress over the past several years toward meeting the goal of the ACA to give all Americans the opportunity to enroll in comprehensive health insurance at an affordable price. For individuals who were previously uninsured, the ACA expanded eligibility for Medicaid and created new Exchanges for eligible individuals to purchase QHPs subsidized by the PTC. Research has shown that these policies increased access to affordable health insurance and helped reduce the share of the population that was uninsured.²¹

Despite this progress, roughly 26 million people still lack health insurance coverage. About 8 percent of the population is still uninsured.²² Because these people without health coverage face large, unpredictable bills when they seek medical care, many forgo necessary treatments. The key challenge for these families in obtaining coverage is the cost of coverage. According to the National Health Interview Survey, nearly 75 percent of uninsured adults reported the main reason they were uninsured was because the coverage options available to them were not affordable.²³ Additionally, millions of adults reported that in order to save money, they did not get needed medical care or take medication as prescribed.²⁴

Premium costs are particularly challenging for families enrolling in employer coverage. Since the 2013 regulations were promulgated, the average annual employee contribution for family coverage has increased by over 30 percent—a growth rate that is nearly double the rate at which the Consumer Price Index increased over the same period.²⁵ In 2021, the average

²⁰ See <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53094-acaprojections.pdf>.

²¹ <https://onlinelibrary.wiley.com/doi/epdf/10.1002/pam.22158>.

²² <https://aspe.hhs.gov/reports/2022-uninsurance-at-all-time-low>.

²³ <https://www.cdc.gov/nchs/data/databriefs/db382-H.pdf>.

²⁴ <https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease202204.pdf>.

²⁵ <https://www.bls.gov/cpi/data.htm>.

annual employee contribution for a family plan offered by the employer was \$5,969. Contributions were even higher for employees at small firms who faced an average cost of \$7,710. Roughly 12 percent of workers offered health coverage would have had to pay over \$10,000 to cover their entire family.²⁶ Under the 2013 regulations, these families are not eligible for the PTC if the self-only coverage offer is affordable, even if the cost of family coverage exceeds their annual income. Without access to affordable coverage from either their employer or the Exchange, some low- and middle-income families are unable to obtain coverage and must go uninsured.

For families that can afford employer coverage, the coverage is sometimes of limited value because of high levels of cost-sharing. In 2020, roughly 90 percent of employer plans had a deductible.²⁷ Among family plans offered by employers with a deductible, the average amount of the deductible was roughly \$3,722. After families reach their deductible, they are usually liable for co-insurance or co-payments until they hit their out-of-pocket maximum. For 2020, the average out-of-pocket maximum for a family plan offered by employers was \$8,867. There is also clear evidence that high levels of cost-sharing can restrict access to necessary medical care and lead to adverse health outcomes.²⁸

Thus, although the ACA has succeeded in providing affordable health care to millions of Americans, some still cannot afford coverage. With increasingly higher premiums and out-of-pocket costs, the cost of family coverage offered by employers has become particularly unaffordable for some employees' family members. The self-only affordability rule for related individuals in the 2013 regulations exacerbates that problem. Although the Treasury Department and the IRS could speculate in 2010–2013 that the self-only affordability rule might adversely affect certain families, the data and subsequent analysis have now borne out those adverse effects.

In addition to the data provided in the studies cited above, numerous health care advocates have written articles over the years describing the adverse effects of the 2013 affordability rule and

recommending a rule change.²⁹ Most recently, the proposed regulations themselves generated over 3,800 comments in support of the proposed rule. As noted earlier in this preamble, many of these commenters recounted personal stories of family members being uninsured due to the unaffordability of family coverage offered by an employer and the unavailability of a PTC for Exchange coverage. Finally, individuals have shared stories in other forums regarding the negative impact of the 2013 affordability rule on their lives. For example, one married couple testified to a state legislature that they divorced solely to retain the husband's eligibility for the PTC after his wife got a new job with an offer of family coverage at a cost of \$16,000, over half of the husband's annual earnings.³⁰

Consistent with E.O. 14009, issued in January 2021, the Treasury Department and the IRS undertook a review of the affordability rule for family members in the 2013 regulations at § 1.36B–2(c)(3)(v)(A)(2). As part of this review, the Treasury Department and the IRS reconsidered the text of the relevant statutes and whether the 2013 affordability rule represents the best reading of that text. As explained above, the Treasury Department and the IRS now believe (in contrast to their view in 2013) that the 2013 affordability rule did not represent the best reading of the statutory text. The Treasury Department and the IRS also considered the evidence described above from the intervening years and evaluated whether the 2013 affordability rule is inconsistent with the overall goal of the ACA in providing comprehensive, affordable health coverage, as well as the goal of improving access to quality and affordable health care.³¹ This evaluation was informed by the experience of the intervening years since Exchange coverage and the PTC first became available. The evaluation demonstrated adverse impacts of the 2013 regulations on families and prompted the Treasury Department and the IRS to issue the proposed regulations and solicit public comments.

In addition, the Treasury Department and the IRS now have a clearer idea of the potential cost and the coverage

benefits of changing the affordability rule, in part because of the time that has elapsed since the issue was last considered and the experiences of different insurance markets during that time. For example, analysis has shown how adopting the policies in the final rule would increase access to affordable Exchange coverage.³² Newly insured individuals will receive substantial benefits. Recent academic research suggests that enrollment in Exchange coverage provides financial protection and improves health outcomes.³³ Several commenters on the proposed regulations also cited publicly available studies that estimate the impact of the proposed affordability rule for related individuals on Federal outlays and revenues.

In addition, several commenters cited publicly available studies that estimate how changing the affordability rule for related individuals could affect the number of people with health insurance coverage.³⁴ One commenter presented estimates based on their own simulation of health insurance coverage decisions. Another commenter cited a study that focused specifically on the state of California.³⁵ Since the comment period on the proposed regulations ended, analysts have continued to estimate the impact of changing the affordability rule.³⁶

The studies cited by commenters found that implementing a policy similar to the affordability rule described in the proposed regulations would increase the number of individuals eligible for financial assistance by between 3 million and 5.1 million. Other studies project that, out of those newly eligible, between 600,000 and 2.3 million individuals would

²⁶ <https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/>.

²⁷ https://www.meps.ahrq.gov/data_files/publications/cb25/cb25.pdf.

²⁸ <https://academic.oup.com/qje/article-abstract/132/3/1261/3769421; https://www.nber.org/papers/w28439>.
²⁹ See, for example, Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers | Center on Budget and Policy Priorities (cbpp.org); <https://www.healthaffairs.org/do/10.1377/forefront.20210520.564880/>.

³⁰ See <https://legislature.maine.gov/legis/bills/getTestimonyDoc.asp?id=161949>.
³¹ See H.R. Rep. No. 111–443 (2009).

³² <https://laborcenter.berkeley.edu/wp-content/uploads/2022/06/Fact-Sheet-Family-Glitch.pdf>.

³³ https://www.cbo.gov/system/files?file=2022-07/58313-Crapo_letter.pdf.

choose to enroll in Exchange coverage.³⁷ Estimates of the number of people who would be newly insured range from 80,000 to 700,000. These studies estimate that this change in eligibility and subsequent enrollment would increase the Federal deficit by between approximately \$2.6 billion and \$4.5 billion per year on average.

The studies also discussed which types of families would be most likely to benefit from the proposed affordability rule for related individuals. Families with incomes below 250 percent of the Federal poverty level and families with employees who work for small employers were expected to benefit the most. One study found that workers in industries such as service, agriculture, mining, and construction were more likely to be eligible for a PTC.³⁸ Another study estimated that families switching from employer coverage to Exchange coverage would save an average of about \$400 per person in premiums per year.³⁹ The studies also discussed how certain qualifying individuals would benefit from cost-sharing reductions that are available for certain qualified individuals enrolling in Exchange coverage.

These studies provide a range of estimated impacts on health coverage status and the Federal deficit. Each study relies on different data sources, modeling techniques, behavioral assumptions, and budgetary baselines. Additionally, the policies they simulate are different than the exact set of policies being adopted in the final regulations. The Treasury Department and the IRS also note that there is a substantial amount of uncertainty in estimating the impact of the policy change.⁴⁰

In addition to these studies—those cited by commenters, as well as others reviewed by the Treasury Department and the IRS—the Treasury Department's

³⁷ Some studies estimated any Exchange enrollment while other studies estimated only subsidized Exchange enrollment.

³⁸ <https://www.kff.org/health-reform/issue-brief/many-workers-particularly-at-small-firms-face-high-premiums-to-enroll-in-family-coverage-leaving-many-in-the-family-glitch/>.

³⁹ https://www.urban.org/sites/default/files/publication/104223/changing-the-family-glitch-would-make-health-coverage-more-affordable-for-many-families_1.pdf.

⁴⁰ None of the studies reviewed by the Treasury Department and the IRS provided a quantitative measure of the level of uncertainty associated with their estimates. For example, the studies did not report sensitivity checks describing how their results would change under different modeling assumptions. Additionally, none of the studies reported standard errors, a statistic that researchers use to quantify sampling error and the significance of any differences.

Office of Tax Analysis has conducted its own analysis as to the effect of the policy change on health insurance coverage decisions and the Federal deficit. The policy change is projected to increase the number of individuals with PTC-subsidized Exchange coverage by about 1 million and increase the Federal deficit by an average of \$3.8 billion per year over the next 10 years. The projections from this analysis are within the range of predictions reported in the cited studies. The evaluation focused on direct, predictable effects of the regulation. Although some studies predict the affordability rule may incidentally increase enrollment in Medicaid or CHIP, these effects are indirect and speculative. Taken as whole, the Treasury Department and the IRS conclude that these analyses provide compelling evidence that the new affordability rule for related individuals will increase the affordability and accessibility of health insurance. Although the range of numbers indicate there is uncertainty in the precise number of individuals who will be affected, the studies suggest that the final regulations will succeed in achieving two key policy goals of the ACA: increasing coverage and reducing costs for consumers. These studies, and the Treasury Department's own analysis, lead the Treasury Department and the IRS to believe that the proposed affordability rule, as finalized in these regulations, is consistent with the overall goals of the ACA and is based on sound reasons for a revision to the affordability rule. Further, as explained in section II of this Summary of Comments and Explanation of Revisions, the Treasury Department and the IRS are of the view that section 36B(c)(2)(C)(i) is better interpreted in a manner that requires consideration of the premium cost to the employee to cover not just the employee, but also other members of the employee's family who may enroll in the employer coverage. Thus, the Treasury Department and the IRS adopt in these final regulations the proposed affordability rule for related individuals that is based on the cost of family coverage because they have concluded that such a rule is the better reading of the statute. For the reasons stated in section II of this Summary of Comments and Explanation of Revisions, the Treasury Department and the IRS have also concluded that, to the extent there is ambiguity in the statute, the proposed affordability rule would be the better alternative to resolve that ambiguity and to implement the statute in a way

consistent with Congress's purposes in enacting the ACA.

IV. Recommended Amendments to Proposed Rules

A. Cost of Family Coverage

Under the proposed regulations, an eligible employer-sponsored plan would be treated as affordable for related individuals if the portion of the annual premium the employee must pay for family coverage, that is, the employee's required contribution, does not exceed 9.5 percent of household income. For this purpose, § 1.36B-2(c)(3)(v)(A)(2) of the proposed regulations provided that an employee's required contribution for family coverage is the portion of the annual premium the employee must pay for coverage of the employee and all other individuals included in the employee's family, as defined in § 1.36B-1(d), who are offered coverage under the eligible employer-sponsored plan. Under § 1.36B-1(d), an employee's family consists of the employee, the employee's spouse filing a joint return with the employee, and the employee's dependents.

A few commenters requested a change to § 1.36B-2(c)(3)(v)(A)(2) of the proposed regulations. Under the rule suggested by the commenters, an employee's required contribution for family coverage under § 1.36B-2(c)(3)(v)(A)(2) would be the portion of the annual premium the employee must pay for coverage of the employee and all other individuals offered the employer coverage as a result of their relationship to the employee, including non-dependents of the employee who may enroll in the employer coverage (non-family members). As noted by the commenters, many employers offer coverage to employees' children up to age 26 without regard to whether a child is a dependent of the employee.⁴¹ The commenters argued that including the cost to cover all individuals offered the coverage in an employee's required contribution will ensure that all of these individuals, including non-family members, have access to affordable coverage.

The Treasury Department and the IRS do not adopt this comment. Under the final regulations, as in the proposed

⁴¹ Under Public Health Service Act section 2714, which is incorporated into the Code through Code section 9815 and into the Employee Retirement Income Security Act (ERISA) through section 715 of ERISA, group health plans and health insurance issuers offering group or individual health insurance coverage that offer dependent coverage for children must make that coverage available to employees' children until they attain age 26. See 26 CFR 54.9815-2714, 29 CFR 2590.715-2714, and 45 CFR 147.120.

regulations, the cost of covering individuals who are offered the coverage but are non-family members is not considered in determining whether the employee's family members have an offer of affordable employer coverage. Under § 1.36B–2(c)(4)(i), an individual who may enroll in employer coverage as a result of the individual's relationship to an employee, but who is a non-family member, is treated as eligible for the employer coverage only if he or she is enrolled in the coverage. Consequently, an individual who may enroll in employer coverage, but who is a non-family member, does not need a determination of unaffordable coverage to enroll in a QHP and be eligible for the PTC, if the individual otherwise qualifies. Unlike family members, a non-family member may enroll in a QHP and be eligible for the PTC, if the individual is otherwise eligible, by simply not enrolling in the offered employer coverage. Accordingly, the cost of covering non-family members should not be considered in determining whether other related individuals have an offer of affordable employer coverage.

B. Determine Affordability for Employees Based on the Cost of Family Coverage

Under § 1.36B–2(c)(3)(v)(A)(1), an eligible employer-sponsored plan is considered affordable for an employee offered coverage under the plan if the employee's required contribution for self-only coverage does not exceed 9.5 percent of household income. The proposed regulations do not change the affordability rule for employees.

Several commenters requested that the final regulations amend the affordability rule for employees to provide that, if an offer of employer coverage is unaffordable for an employee's family members, the offer would also be considered unaffordable for the employee. The commenters noted that separate affordability rules for employees and family members will sometimes result in a spouse or dependent of an employee having an offer of employer coverage that is unaffordable even though the employee has an affordable offer of self-only coverage. This could cause families to enroll in multiple plans or policies, the employee in the employer plan and the family members in a QHP, which would be burdensome and costly for families who must navigate different provider networks and drug formularies and incur separate deductibles and caps on out-of-pocket spending.

Although the Treasury Department and the IRS understand the concerns

raised by the commenters, the affordability rule for employees is specifically provided in section 36B(c)(2)(C)(i) and cannot be changed by regulation. Under section 36B(c)(2)(C)(i), an employee is not eligible for minimum essential coverage under an employer plan if the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of household income. Section 5000A(e)(1)(B) provides that the term "required contribution" means, "in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage." Further, the affordability rule in section 5000A(e)(1)(C) applies only to related individuals and not to employees. Consequently, the final regulations do not amend the affordability rule for employees.

C. Multiple Offers of Coverage

The proposed regulations provided that an individual who has offers of employer coverage from multiple employers has an offer of affordable coverage if at least one of the offers of coverage is affordable. For example, if X has an offer of employer coverage from X's employer and also from the employer of X's spouse, Y, for a year for which X and Y file a joint return, X has an offer of affordable coverage if either X's required contribution for self-only coverage under X's employer's plan does not exceed 9.5 percent of X's and Y's household income, or if Y's required contribution for family coverage under Y's employer's plan does not exceed 9.5 percent of X's and Y's household income. One commenter suggested that the Treasury Department and the IRS reconsider this multiple coverage rule as it may be confusing for individuals with multiple offers of coverage; however, the commenter did not include a recommendation for a specific change to the regulations.

The final regulations do not change the rule provided in the proposed regulations regarding affordability for individuals with multiple offers of coverage. Although the current section 36B regulations do not explicitly address situations involving multiple offers of employer coverage, as noted in the Background section of this preamble, a month is a coverage month for an individual only if the individual is not eligible for MEC, other than

individual market coverage, for the month. Therefore, under the current regulations, an individual with multiple employer coverage offers for a month is eligible for MEC for that month if at least one of the offers of coverage is affordable and provides minimum value. The rule in the proposed regulations relating to multiple offers of coverage simply states expressly how the affordability rule in the current regulations applies to an individual with multiple offers of employer coverage.

Furthermore, an individual with multiple offers of employer coverage seeking to enroll in a QHP with APTC would provide information to the applicable Exchange concerning the required contribution for each coverage offer. The Exchange will determine if at least one of the offers is affordable, in which case APTC would not be allowed for the individual's Exchange coverage. This process should minimize any burden or confusion relating to whether an individual with multiple offers of coverage has an affordable offer that would deny the individual APTC and PTC for his or her Exchange coverage. In addition, for taxpayers for whom APTC is not paid for their or their family's QHP coverage, the IRS will update the instructions for Form 8962, *Premium Tax Credit (PTC)*, and Publication 974, *Premium Tax Credit (PTC)*, to address multiple offers of employer coverage.

D. Comments Requiring Legislative Changes

One commenter suggested that the final regulations include a rule under which an employee and the employee's family members are not considered to have an offer of affordable coverage if the cost of coverage for the entire family is more than 15 percent of household income. One commenter asked that the rule in section 36B(c)(2)(B) be amended and that all individuals offered coverage under an employer plan be permitted to choose between the employer coverage and Exchange coverage with a PTC. Another commenter requested that the Treasury Department and the IRS make permanent the rule in section 36B(c)(1)(E) under which taxpayers with household income above 400 percent of the applicable Federal poverty line may qualify for a PTC for taxable years beginning in 2021 and 2022.⁴² One

⁴² Section 12001 of Public Law 117–169, 136 Stat. 1818 (August 16, 2022), commonly known as the Inflation Reduction Act of 2022 (IRA), extended through 2025 the rule in section 36B(c)(1)(E) under which taxpayers with household income above 400 percent of the applicable Federal poverty line may qualify for a PTC.

commenter requested that the rules of section 36B be amended so that a PTC for a child may be claimed by the taxpayer who pays for the health insurance coverage of the child, not to the taxpayer claiming the child as a dependent. Finally, one commenter suggested that the final regulations include a rule under which excess APTC repayments would be waived for taxable year 2023 while the Exchanges adjust and reeducate consumers on the affordability calculation for family members.

The Treasury Department and the IRS appreciate these comments but note that these changes would require legislative action and cannot be made by regulation. Thus, the final regulations do not include these recommended rules.

E. ICHRA and QSEHRA Comments

In general, § 1.36B–2(c)(3)(i)(B) provides affordability rules related to employees who are offered a health reimbursement arrangement (HRA) or other account-based group health plan that would be integrated with individual health insurance coverage if the employee enrolls in individual health insurance coverage (an individual coverage health reimbursement arrangement or ICHRA). Those rules provide that an individual who is offered an ICHRA because of a relationship to the employee (a related HRA individual) is eligible for minimum essential coverage under an eligible employer-sponsored plan for any month for which the ICHRA is offered if (1) the ICHRA is affordable, or (2) the employee does not opt out of and waive future reimbursements from the ICHRA, regardless of whether the ICHRA is affordable. Under § 1.36B–2(c)(5), an ICHRA is affordable for a month if the employee's required HRA contribution does not exceed 9.5 percent of the employee's household income for the taxable year, divided by 12. An employee's required HRA contribution is the excess of the monthly premium for the lowest cost silver plan for self-only coverage of the employee offered in the Exchange for the rating area in which the employee resides, over the monthly self-only ICHRA amount (or the monthly maximum amount available to the employee under the ICHRA if the ICHRA provides for reimbursements up to a single dollar amount regardless of whether an employee has self-only or other-than-self-only coverage).

One commenter stated it was unclear whether the affordability rule for related individuals in the proposed regulations applies to ICHRAs. The commenter also

suggested that the final regulations include a rule under which family coverage amounts, not self-only coverage amounts, are used to determine whether an ICHRA offer to a related HRA individual is affordable.

The proposed regulations do not address the affordability rules relating to an ICHRA offer, and, consequently, the final regulations also do not address ICHRAs. Therefore, the rules for determining affordability of an ICHRA remain unchanged. However, the Treasury Department and the IRS, in coordination with HHS and the U.S. Department of Labor (DOL), will consider whether future guidance should be issued to change the ICHRA affordability rules for related HRA individuals in the manner suggested by the commenter.

Other commenters suggested that a PTC be allowed for family members in situations in which an employee is offered an affordable HRA, whether an ICHRA or a QSEHRA, and does not opt-out of the HRA. The commenters recommended that, in these situations, the employee and the family members would enroll in an Exchange family plan and the employee would not be allowed a PTC because of the affordable HRA, but the family members would be allowed a PTC.

The rules relating to QSEHRAs are specifically provided by statute in section 36B(c)(4). Because the Treasury Department and the IRS cannot amend those rules by regulation, QSEHRAs are not addressed in these final regulations.

Under the rules for ICHRAs, if the terms of the ICHRA provide that reimbursements are allowed only for the medical expenses of the employee and not for the expenses of related individuals, a PTC may be allowed for the Exchange coverage of the related individuals, irrespective of whether the ICHRA is considered affordable under § 1.36B–2(c)(5), or whether the employee opts out of the ICHRA. However, if the ICHRA offer includes reimbursements of the medical expenses of related HRA individuals, a PTC is generally not allowed for the Exchange coverage of the employee or the related HRA individuals if the ICHRA offer is affordable or if the employee does not opt out of the ICHRA. This is because an ICHRA is an eligible employer-sponsored plan under section 5000A(f)(2) and, therefore, under section 36B(c)(2)(C), if the coverage is affordable and provides minimum value, a PTC is generally not allowed for the Exchange coverage of an individual to whom the ICHRA offer extends or who does not opt out of the ICHRA. Consequently, this rule relating to offers

of employer coverage in section 36B(c)(2)(C) cannot be amended by regulation. However, as noted in connection with the prior comment concerning ICHRAs, the Treasury Department and the IRS, in coordination with HHS and DOL, will consider whether future guidance should be issued to provide an ICHRA affordability rule for related individuals that is separate from the affordability rule for employees.

F. Minimum Value

1. Minimum Value Rule for Related Individuals

The proposed regulations provided that an employer plan meets the minimum value requirement for related individuals if the plan's share of the total allowed costs of benefits provided to related individuals is at least 60 percent, similar to the minimum value requirement for employees. One commenter requested that the final regulations include a minimum value safe harbor rule under which an employer plan is considered to provide minimum value to related individuals if the coverage provided to employees under the plan meets minimum value requirements and the same benefits are provided to employees and family members. Other commenters recommended that the final regulations allow for the calculation of minimum value using a standard population that includes both employees and dependents to calculate a single, composite, minimum value for an employee and dependents, and that separate populations not be required for coverage provided to employees and coverage provided to related individuals.

As in the proposed regulations, the final regulations provide a minimum value rule for related individuals that is separate from the minimum value rule for employees, and that requires a plan's share of the total allowed costs of benefits provided to related individuals to be at least 60 percent. This minimum value rule for related individuals is not intended to require the use of a standard population for family members that is separate from the standard population for employees. Rather, the intent of the rule is to ensure that employers continue to provide a plan that has the same benefit design for employees and related individuals, and not to burden employers with having to offer different benefit packages for employees and related individuals. Consequently, the final regulations include a rule providing that an employer plan that provides minimum value to an

employee also provides minimum value to related individuals if the scope of benefits and cost sharing (including deductibles, co-payments, coinsurance, and out-of-pocket maximums) under the plan are the same for employees and family members. If cost sharing varies based on whether related individuals are enrolled and/or the number of related individuals enrolled (that is, the tier of coverage), minimum value for related individuals is based on the tier of coverage that would, if elected, cover the employee and all related individuals (disregarding any differences in deductibles or out-of-pocket maximums that are attributable to a different tier of coverage, such as self plus one versus family coverage.) In addition, the final regulations do not require a departure from the practice of computing minimum value for employees and related individuals based on the provision of benefits to a standard population that includes both employees and related individuals.

2. Require Coverage of All Essential Health Benefits

The proposed regulations provided that, to be considered to provide minimum value, an eligible employer-sponsored plan must include substantial coverage of inpatient hospital services and physician services. One commenter asked that final regulations provide that an employer plan does not meet the minimum value requirements unless it provides coverage of all 10 essential health benefits that, under the ACA, certain plans must cover, not just inpatient hospital services and physician services. This comment requesting an expansion of the minimum value rule is outside the scope of these final regulations. Thus, as in the proposed regulations, the final regulations provide that an eligible employer-sponsored plan does not meet minimum value requirements unless it includes substantial coverage of inpatient hospital services and physician services.

3. Minimum Value Calculator

Under 45 CFR 156.145(a)(1), a minimum value calculator is to be made available by HHS and the IRS that an employer plan may use to determine whether the percentage of total allowed costs under the plan is at least 60 percent. Several commenters requested that the minimum value calculator be updated to reflect more current large group data and to incorporate appropriate model changes that have been made to the actuarial value

calculator.⁴³ Although the commenters' request concerning the minimum value calculator is outside the scope of the final regulations, the Treasury Department and the IRS have shared these comments with HHS to determine the best way to address these comments relating to the calculator.

G. Applicability Date of Final Regulations

The proposed regulations provided that the changes to §§ 1.36B–2, 1.36B–3, and 1.36B–6(a)(2) in the proposed regulations, if finalized, were expected to apply for taxable years beginning after December 31, 2022. Several commenters requested instead that the final regulations apply for taxable years beginning after December 31, 2023. These commenters expressed concern that taxpayers will be faced with a number of health care-related changes in 2022, including the end of the temporary applicable percentages for 2021 and 2022 in section 36B(b)(3)(A)(iii) that increased PTC amounts.⁴⁴ Commenters also noted that at the end of the COVID–19 public health emergency, states will no longer be required to comply with a Medicaid continuous enrollment requirement in order to receive a temporary increase in Federal Medicaid matching funds under the Families First Coronavirus Response Act. The commenters stated that these changes, along with the changes in the proposed regulations, will result in much uncertainty for QHP enrollees for the open enrollment period that begins on November 1, 2022, and will lead to substantial confusion for QHP enrollees and likely inaccurate APTC determinations by Exchanges.

Although the commenters' concerns are appreciated, the Treasury Department and the IRS are of the view that those concerns are outweighed by the goal of allowing spouses and dependents, some of whom have been negatively affected by the 2013 affordability rule, to be able to access affordable Exchange coverage beginning in the 2023 plan year. For this reason, many commenters urged the Treasury Department and the IRS to implement the changes to the affordability rule for related individuals in time for QHP open enrollment for the 2023 plan year. Although 2023 QHP enrollment may

present some new challenges, as discussed more fully in section IV of this Summary of Comments and Explanation of Revisions, HHS has informed the Treasury Department and the IRS that HHS will engage in thorough implementation efforts, including revising the Exchange application and providing resources and technical assistance education for State Exchanges, Navigators, agents, brokers, and other assisters to help enrollees understand their options for 2023. In addition, the IRS will be making changes to its forms, instructions, publications, and website, in an effort to educate taxpayers about any changes for the 2023 plan year. Therefore, the Treasury Department and the IRS do not adopt the commenters' request that the applicability date of the final regulations be delayed until taxable years beginning after December 31, 2023. Instead, the final regulations apply for taxable years beginning after December 31, 2022.

Another commenter urged that the Treasury Department and the IRS consider the effective date implications of this rule for the State Innovation Waiver program under section 1332 of the ACA (section 1332 waivers). The commenter requested that the Administration consider the implications of the final regulations on states with approved section 1332 waivers and, if necessary, identify a plan to mitigate potential harm to accessing affordable coverage for individuals. For example, the commenter expressed concern that states would need to develop and update actuarial analyses for section 1332 waivers and that there would be an impact on states leveraging Federal pass-through funding under section 1332 waivers, mostly through reinsurance programs, given that the proposed regulations would modify who is eligible for the PTC and APTC. The commenter also was concerned that there may be implications for states exploring other innovative opportunities, such as public health insurance options that enhance affordable options by leveraging section 1332 Federal pass-through funding.

The section 1332 waiver program permits states to apply to waive certain provisions of the ACA, including section 36B of the Code, to undertake their own state-specific reforms to provide residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. A state applying for a section 1332 waiver must include in its application actuarial and economic analyses that demonstrate that the

⁴³ Under 45 CFR 156.135, HHS is responsible for developing and updating an actuarial value calculator that issuers may use to determine the actuarial value of a health plan.

⁴⁴ Under section 12001 of the IRA, the temporary applicable percentages for 2021 and 2022 in section 36B(b)(3)(A)(iii) were extended through 2025 so taxpayers will not see a change in their PTC amount due to the potential policy change described by commenters.

waiver proposal meets the statutory requirements for section 1332 waivers.⁴⁵⁴⁶ If a waiver yields Federal savings on certain forms of Federal financial assistance under the ACA (such as the PTC), those savings are passed through to the state to help implement the state's approved waiver plan. Federal pass-through funding amounts are calculated annually by the Treasury Department and HHS. Pass-through amounts reflect current law and policy at the time of the calculation but can be updated, as necessary, to reflect applicable changes in Federal or state law.⁴⁷ The Treasury Department plans to work with HHS to communicate any implications of these final regulations, including any associated requirements for states, to affected stakeholders and to states that have approved section 1332 waivers or that are considering section 1332 waivers. The Treasury Department and the IRS recognize that the final regulations may affect states in different ways but believe that any negative effects related to the effective date are outweighed by the goal, supported by numerous commenters, of allowing more spouses and dependents to be able to access affordable Exchange coverage beginning in 2023. The Treasury Department and the IRS also note that further innovation under section 1332 of the ACA is speculative, and that, in any event, section 1332 waiver policies are outside the scope of these regulations.

V. Comments Regarding Outreach

Several commenters requested that HHS, the Treasury Department, and the IRS provide clear resources aimed at helping various individuals and employers. Many of the commenters who requested that HHS, the Treasury Department, and the IRS provide outreach about the new rules were concerned about families understanding the trade-offs if they are considering "split coverage," meaning that the employee would enroll in employer coverage and the family members would enroll in Exchange coverage. Some commenters noted that split coverage could lead to lower premiums for the family or could lead to uninsured individuals gaining coverage. Those commenters also noted, however, that some families with split coverage will need to contend with different provider networks, deductibles, out-of-pocket limits, open enrollment periods, appeals and grievance procedures, and other parameters unique to their different

health plans. Another commenter added that for some families, moving family members from employer coverage to Exchange coverage could mean lower HRA or health savings account contributions from employers. One commenter stated that confusion about split coverage could present particular difficulties for those with limited English proficiency or lower rates of health literacy.

The commenters who raised these concerns all supported the affordability rule for related individuals provided in the proposed regulations, but requested that the Treasury Department and the IRS work with HHS to help ensure that families who choose to enroll in split coverage will benefit from doing so. One commenter stated that families considering whether to enroll in Exchange coverage with a PTC in lieu of enrolling in employer coverage would greatly benefit from resources and guidance that help them make an informed purchasing decision. That commenter urged the Treasury Department and the IRS to work with HHS on how to best communicate that information in an accessible fashion to consumers both generally and as part of the Exchange application. Finally, one commenter noted that numerous studies show there is a correlation between advertising about the ACA and an increase in individuals shopping for, and enrolling in, Exchange coverage. Thus, that commenter suggested that the IRS and HHS should reinvigorate efforts to educate the American public about Exchange open enrollment (Open Enrollment), specifically focusing on this change to the affordability rule for related individuals.

The Treasury Department and the IRS understand that the new affordability rule in these final regulations will present families with additional coverage options they will need to understand, evaluate, and compare to determine the type of coverage that is best for them. The Treasury Department and the IRS have been working with HHS, and will continue to work with HHS, to ensure that the agencies communicate information about the new rules in an accessible fashion to individuals both generally and as part of the Exchange application. Specifically, HHS has informed the Treasury Department and the IRS that HHS will work to revise the Exchange application on *HealthCare.gov* in advance of Open Enrollment for the 2023 plan year to include new information that will assist consumers in filling out their applications. Those revisions will include (1) new questions on the application about employer coverage

offers for family members, and (2) revised materials for consumers to gather information from their employer about the coverage being offered. To assist those with limited English proficiency, *HealthCare.gov* offers language services upon request through the Marketplace Call Center, and the *HealthCare.gov* application is available in both English and Spanish.

The Treasury Department and the IRS also understand that HHS will provide resources and technical assistance to State Exchanges that will need to make similar changes on their websites and Exchange application experiences. More generally, HHS is working regularly with State Exchanges to provide technical assistance on implementation of the new rules. HHS continues to track State Exchange planning and take all necessary steps to support efforts by State Exchanges to implement the new rules, with necessary outreach and education efforts, for Open Enrollment for the 2023 plan year.

In addition, the Treasury Department and the IRS understand that HHS will provide training on the new rules to agents, brokers, and other assisters (for example, Navigators) so applicants will better understand their options before enrolling, including the trade-offs if applicants are considering split coverage. This training is particularly important because over half of the applicants who apply for Exchange coverage through *HealthCare.gov* are assisted by an agent, broker, or other assister. HHS also will share available resources with State Exchanges to leverage for use in training customer support personnel in their states.

Finally, HHS has informed the Treasury Department and the IRS that HHS is considering outreach to specific consumers. HHS has data from prior years on applicants who applied through a Federally-facilitated Exchange, were denied APTC at enrollment, and might benefit from the new rules. HHS is evaluating opportunities for direct outreach to these individuals.

The IRS also will need to implement the new rules for the 2023 taxable year. In particular, the IRS will update relevant forms, instructions, and publications prior to the tax filing season for 2023, to include the instructions for Form 8962 and Publication 974. In addition, the IRS will update relevant materials on *IRS.gov* to provide taxpayers with additional information about the new rules.

In addition to the commenters requesting that HHS, the Treasury Department, and the IRS provide

⁴⁵ See 31 CFR 33.108(f)(4)(i) and (ii); 45 CFR 155.1308(f)(4)(i) and (ii).

⁴⁶ Section 1332(b)(1)(A)–(D) of the ACA.

⁴⁷ 31 CFR 33.122 and 45 CFR 155.1322.

outreach to individuals, a few commenters provided specific recommendations related to employers. One commenter stated that employers are thinking about ways to educate employees affected by this new change but suggested that resources be made available from HHS, the Treasury Department, and the IRS that could be shared with employees. One commenter suggested that the Treasury Department, in coordination with HHS and the U.S. Department of Labor, issue tri-agency guidance and consumer-friendly resources to help employees navigate challenges that arise from split coverage. One commenter stated that the Treasury Department and the IRS should require employers to provide notification to their employees about the new affordability test, including information about Exchange coverage, the availability of financial assistance, and how an individual may enroll in coverage. The commenter also recommended that the Treasury Department and the IRS invite stakeholder feedback on a draft of a model notice that employers could share with employees. Finally, one commenter stated that the new rules will create new requirements for plan sponsors and administrators to ensure compliance with the rules and recommended that the Treasury Department and the IRS issue a Request for Information to better understand the recordkeeping and compliance needs of stakeholders who will be affected by the final rule.

The Treasury Department and the IRS appreciate that employers are interested in providing information to their employees about the new rules and encourage employers to provide employees with resources published by DOL, HHS, the Treasury Department, and the IRS relating to the new rules. Regarding the suggestion to impose a notification requirement on employers, such a requirement is outside the scope of section 36B and these final regulations. Thus, the Treasury Department and the IRS cannot impose a notification requirement on employers through these final regulations. In addition, the Treasury Department does not intend to issue formal tri-agency guidance with HHS and DOL or publish a model notice. However, the agencies understand the need to provide clear, consumer-friendly resources that can be accessed by individuals in various ways, including through employers who want to provide those resources directly to employees. Therefore, the Treasury Department and the IRS, in coordination with HHS and DOL, will work to ensure

that outreach materials about these final regulations can be accessed by individuals or by employers who choose to share the materials with their employees. In addition, the agencies plan to coordinate in conducting open door forums with employers, employer associations, and employee benefits managers to educate them about the new rules.

As noted earlier, one commenter stated that the new rules will create new recordkeeping and compliance requirements for plan sponsors and administrators. However, nothing in the proposed rules specifically imposed any new requirements on plan sponsors or administrators and any such requirements would be outside the scope of section 36B. In addition, as discussed later, the new rules in these final regulations do not create, even indirectly, any new recordkeeping or compliance requirements for plan sponsors or administrators.

VI. Issues for Employers

A. Information Reporting

Multiple commenters pointed out that the proposed regulations did not address whether the regulations would impose new information reporting obligations on employers and other providers of minimum essential coverage under sections 6055 and 6056. Section 6055 requires providers of minimum essential coverage to report coverage information by filing information returns with the IRS and furnishing statements to individuals. Section 6056 requires ALEs to file information returns with the IRS and furnish statements to full-time employees relating to health coverage offered by an ALE to its full-time employees and their dependents. Some commenters noted that the composition of an employee's tax family is not readily ascertainable by an employer, no employer collects the type of information that would allow them to make determinations about the employment status and health coverage of family members, and this data would be costly and burdensome to collect and report.

The Treasury Department and the IRS clarify that nothing in these final regulations affects any information reporting requirements for employers, including the reporting required under sections 6055 and 6056, which is done on Form 1095-B, *Health Coverage*, and Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*, respectively. Further, these final regulations do not amend the regulations under section 6055 or 6056,

and the IRS does not intend to revise Form 1095-B or Form 1095-C to require any additional data elements related to the new rules. Additionally, the safe harbors that an employer may use to determine affordability for purposes of the employer shared responsibility provisions under section 4980H continue to be available for employers.

B. Non-Calendar Year Plans

One commenter expressed concern about how the affordability rule for related individuals would affect family members enrolled in non-calendar year employer plans, especially individuals enrolled in employer coverage through section 125 cafeteria plans (cafeteria plans). The commenter noted that under current rules, spouses and dependents of employees cannot, without a qualifying event, discontinue their employer coverage during a plan year if the employee has elected under the cafeteria plan to cover the spouse or dependent under the employer plan.⁴⁸ Thus, under current rules, if as of January 1, 2023, a spouse or dependent enrolled in a non-calendar year employer plan through a cafeteria plan wants to enroll in a QHP as of that date, no PTC would be allowed for the period from January 1, 2023, until the close of the employer plan year in 2023 because the spouse and dependents would have to continue their enrollment in the employer plan. The commenter opined that, because of this issue, the Treasury Department and the IRS should consider making the final regulations effective beginning in 2024 rather than 2023.

Spouses and dependents enrolled in non-calendar year employer plans not associated with cafeteria plans may, subject to the plan rules, disenroll from the employer plan effective on January 1, 2023, and enroll in a QHP with coverage beginning on January 1, 2023. In that situation, a PTC would be allowed for the Exchange coverage of the spouse and dependents if the requirements for a PTC are met, including that the employer plan is not affordable for the spouse and dependents under the rules in § 1.36B-2(c)(3)(v)(A). The rules in § 1.36B-2(c)(3)(v)(B) apply in determining whether the employer plan is affordable for the spouse and dependents for the

⁴⁸ Although current cafeteria plan rules generally prohibit employees, spouses, and dependents from discontinuing their employer coverage during a plan year, Notice 2014-53, 2014-41 I.R.B. 672, permits a cafeteria plan to allow an employee to revoke his or her election under the cafeteria plan for coverage under the employer plan if certain conditions are met. The notice does not allow an employee to revoke an election solely for coverage of the employee's spouse or dependents under the employer plan.

period from January 1, 2023, until the end of the plan year.

For employer plans associated with cafeteria plans, the Treasury Department and the IRS agree with the commenter that, as with employees, spouses and dependents should be able to discontinue their employer coverage during a plan year and enroll in a QHP, and that a PTC should be allowed for their Exchange coverage if the other requirements of section 36B are met. Consequently, simultaneous with the issuance of these final regulations, Notice 2022-41 is being issued to allow employees to revoke coverage in an employer plan associated with a cafeteria plan for family members to allow them to enroll in a QHP.⁴⁹ The notice is effective for elections that are effective on or after January 1, 2023. Thus, because employees will be permitted under the notice to revoke coverage in an employer plan associated with a cafeteria plan beginning in 2023, the issuance of the notice addresses the commenter's concern about the effective date of the final regulations.

C. Section 4980H Liability

One commenter that supported the proposed regulations noted in a footnote that the proposed regulations would not have a direct effect on an ALE's liability for an employer shared responsibility payment with respect to the employees of that ALE. The Treasury Department and the IRS agree with that comment; the employer shared responsibility payment is triggered by the allowance of a PTC with respect to a full-time employee of the ALE. These final regulations may affect a related individual's eligibility for a PTC, but they do not affect an employee's eligibility for a PTC, and thus these final regulations do not affect the liability of the ALE of the employee.

The commenter also noted that the proposed regulations could have an indirect impact on an ALE's liability for an employer shared responsibility payment. That is, an ALE that does not offer affordable, minimum value coverage to some of its full-time employees could have an increase in its payment under section 4980H for full-time employees who were previously ineligible for a PTC based on an offer of coverage from their spouse's employer. The commenter did not request any change in the proposed regulations, but merely noted this scenario. Certainly, an

ALE that has chosen not to offer affordable, minimum value coverage to the requisite number of its full-time employees may have a potential liability for a payment under section 4980H—a risk that the ALE knowingly accepts. Whenever more employees of such an ALE are allowed a PTC, for any reason, the ALE's liability may grow. The Treasury Department and the IRS have considered the interests such an employer might have in retaining the affordability rule in the 2013 regulations, but do not believe that any such ALE would have a meaningful reliance interest in the 2013 affordability rule. Such an ALE is already risking liability under section 4980H due to its failure to offer affordable self-only coverage to its employees, and has avoided or limited that liability solely through the happenstance that one or more of its employees has received an offer of coverage through a family member that the 2013 affordability rule deemed to be affordable. After careful consideration of this potential interest and broader policy considerations, the Treasury Department and the IRS are adopting these final rules to give full effect to the statutory language and to promote the ACA's goal of providing affordable, quality health care for all Americans.

VII. Procedural Requirements for Regulations and Cost of New Rules

A few commenters argued that the proposed affordability rule for related individuals would be too costly, producing an inefficient use of Federal resources. These commenters all cited a report from the CBO estimating the costs of H.R. 1425, introduced during the 116th Congress, which included provisions that would have amended section 36B to provide an affordability rule for related individuals similar to the one in the proposed regulations. See section 103 of H.R. 1425. According to the CBO analysis, that provision would have increased Federal deficits by \$45 billion over ten years.⁵⁰

The Treasury Department and the IRS acknowledge that multiple analyses have been undertaken since 2013 that analyze the impact of the 2013 interpretation and estimate any impact of changing the policy of the affordability rule. These analyses consider several aspects of the policy change, including the estimated impact on the Federal deficit, the change in individuals' health coverage status, and the estimated increase in PTC. The Treasury Department and the IRS

reviewed the CBO analysis of H.R. 1425, more recent CBO analyses, and other studies that were cited by commenters. In addition to the CBO analysis referred to by commenters, CBO has released an updated analysis estimating that the proposed affordability rule for related individuals, if finalized, would increase the deficit by approximately \$3.4 billion annually on average.⁵¹ Further, the Treasury Department analysis indicates a potential increase in the Federal deficit by an average of \$3.8 billion per year over the next 10 years. These analyses are discussed in section III of this Summary of Comments and Explanation of Revisions. However, the Treasury Department and the IRS disagree that the benefits of the policy change are insufficient to justify the impact on the Federal deficit. As discussed in section III, these studies consistently project an increase in coverage and affordability for a substantial number of individuals. The Treasury Department and the IRS have determined that adding to the Federal deficit to this extent is a worthwhile tradeoff to achieve these policy goals.

Some of those commenters also criticized the Treasury Department and the IRS for not including specific cost estimates in the preamble to the proposed regulations. One commenter argued that the failure to include a cost-benefit analysis in the proposed affordability rule for related individuals violates the Administrative Procedure Act⁵² because it deprives the public of an opportunity for meaningful notice and comment and demonstrates the lack of a reasoned explanation for the rule change.

The Treasury Department and the IRS have provided analysis in accord with the 2018 Memorandum of Agreement between the Treasury Department and the Office of Management and Budget (OMB) (2018 MOA),⁵³ which specifies that the Treasury Department and the IRS will provide qualitative analysis of the potential costs and benefits of tax regulatory actions determined to raise novel legal or policy issues, as described in section 6(a)(3)(B) of E.O. 12866.

Another commenter asserted that the Treasury Department and the IRS did not provide the analyses required by E.O. 12866, E.O. 13563, and the Regulatory Flexibility Act when it

⁴⁹ https://www.cbo.gov/system/files/file=2022-07/58313-Crapo_letter.pdf.

⁵⁰ 5 U.S.C. 551–559.

⁵¹ The Department of the Treasury and the Office of Management and Budget, Memorandum of Agreement, Review of Tax Regulations under Executive Order 12866, April 11, 2018, <https://home.treasury.gov/sites/default/files/2018-04/04-11%20Signed%20Treasury%20OIRA%20MOA.pdf>.

⁵⁰ <https://www.cbo.gov/system/files/2020-06/Combined%20Tables.pdf>.

issued the proposed regulations. EO 12866 and 13563 direct agencies to assess costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits to the American public. The Regulatory Flexibility Act requires the assessment of the numbers of small businesses potentially impacted by the proposed rule. The commenter argued that the analysis contained in the proposed rule lacks quantifiable data and thus is inadequate to satisfy the procedural requirements in E.O. 12866, E.O. 13563, and the Regulatory Flexibility Act.

The commenter first argued that the Treasury Department and the IRS failed to satisfy the requirements of EO 12866 and 13563 because they did not provide a reasoned explanation of the need for regulatory action or an assessment of the costs and benefits of all alternatives. The commenter stated that studies or surveys should have been conducted to assess a more precise number of persons impacted and that the Treasury Department and the IRS failed to quantify the costs of the proposed rule. The commenter asserted that the Treasury Department and the IRS are required to conduct research and assess the costs of all the regulatory alternatives, including the alternative of no action.

The Treasury Department and the IRS disagree. The preamble to the proposed regulations provided a detailed qualitative analysis of the proposed rule's benefits, costs, and transfers. In addition, the Treasury Department and the IRS requested comments regarding data, other evidence, or models. In response to comments, the Special Analyses section of this preamble includes further explanation of the qualitative analysis used by the Treasury Department and the IRS. This analysis meets the requirements of EO 12866 and 13563 applicable to tax regulatory actions and was issued after coordination with and review by OMB under the 2018 MOA.

As noted by the commenter, the Regulatory Flexibility Act generally requires the assessment of the numbers of small businesses potentially impacted by a proposed rule. However, section 605 of the Regulatory Flexibility Act provides an exception under which an assessment is not required if the agency certifies that the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities. If the exception applies, the agency must publish the certification in the **Federal Register** at the time of publication of the proposed rule, along with a statement

providing the factual basis for such certification. The agency also must provide the certification and statement to the Chief Counsel for Advocacy of the Small Business Administration.

In the preamble to the proposed regulations, the Treasury Department and the IRS certified that the proposed regulations would not have a significant economic effect on a substantial number of small entities. The preamble stated that the certification is based on the fact that the majority of the effect of the proposed regulations falls on individual taxpayers, and that entities will experience only small changes. The preamble further noted that the proposed regulations have been submitted to the Chief Counsel for the Office of Advocacy of the Small Business Administration for comment on their impact on small business. Thus, the Treasury Department and the IRS fully complied with the Regulatory Flexibility Act in promulgating the proposed regulations. Further, the Treasury Department and the IRS did not receive any comments from the Small Business Administration regarding the proposed rule's impact on small business. Accordingly, as stated in the Special Analyses section of this preamble, the Treasury Department and the IRS certify that, as with the proposed regulations, these final regulations will not have a significant economic impact on a substantial number of small entities.

VIII. Effect of New Rules on Other Stakeholders

A. Effect of New Rules on Insurance Markets

Several commenters opined that the affordability rule for related individuals provided in the proposed regulations will have an adverse effect on the employer insurance market. In the view of the commenters, one result of changing the affordability rule for related individuals will be that a substantial number of dependents of employees, who are generally younger and healthier than the employees, will shift from employer plans to Exchange coverage. The commenters stated that this shifting of younger, healthier individuals from employer plans to Exchange coverage will result in increased premiums for employer plans. One commenter, however, opined that it is unlikely that the magnitude of the impact on premiums for employer plans would be large. Some commenters pointed out that the shift also will result in decreased premiums for Exchange coverage, but one commenter asserted that the potential impact on the

individual market is likely to be minor. Finally, a few commenters expressed concern that the affordability rule for related individuals will cause employers to discontinue or reduce insurance contributions for the coverage of related individuals. One commenter also mentioned this concern but opined that relatively few employers would take this approach.

The Treasury Department and the IRS do not expect the affordability rule will have a meaningful effect on average premiums for employer plans. Overall, the aggregate amount that employers spend on family coverage is expected to decrease by a small amount because some individuals who would otherwise enroll in employer coverage will prefer to enroll in Exchange coverage with a PTC. Commenters are correct that individuals enrolled in Exchange coverage and individuals enrolled in employer coverage have, on average, different levels of morbidity. However, the Treasury Department and the IRS do not expect that the morbidity of the marginal individual—rather than average individual—is significantly different such that there would be large effects on premiums. In some cases, individuals who would have otherwise enrolled in employer plans may have higher than average costs while in other cases those individuals will have lower than average costs. Furthermore, the number of individuals who are expected to switch plans based on this affordability rule will be modest relative to the over 170 million individuals enrolled in employer health plans. As a result, the net effect on employer premiums—if any—is likely to be negligible.

Because the rule is not expected to have a meaningful impact on premiums for employer coverage, the Treasury Department and the IRS disagree that changes in morbidity would result in employers discontinuing coverage or reducing their contributions to that coverage. Additionally, there are several reasons the Treasury Department and the IRS expect that employers will continue to have strong incentives to offer family coverage. The exclusion of employer coverage from taxable income encourages employers to compensate employees with (and increases employees' demand for) generous health coverage in lieu of taxable wages. In addition, employers face competitive pressure to offer generous family coverage to their employees at a relatively low cost. Employers who reduce their contributions for family coverage may find it difficult to recruit or retain employees. Thus, competitive forces in the labor market will

discourage employers from reducing contributions.

B. Effect of New Rules on Individuals

Some commenters asserted that the proposed affordability rule for related individuals would harm individuals and families in various ways. In particular, commenters argued that individuals and families would face increased complexity as they navigate multiple plan choices, including the choice to enroll in “split coverage” in which the employee with an affordable offer enrolls in self-only employer coverage and the employee’s family members separately enroll in Exchange coverage. Some commenters asserted that the shift to Exchange coverage caused by the proposed rule would be a poor trade-off for individuals and would harm individuals because Exchange coverage in general provides coverage that is inferior to and less generous than employer plans. These commenters asserted, for example, that Exchange coverage may be less expensive than an available employer plan but provide significantly higher deductibles, narrower networks, or lower actuarial value than the available employer plan.

The Treasury Department and the IRS are of the view that providing individuals and families with more choices for health coverage is a positive aspect of the new affordability rule, especially if those additional choices include options for more affordable coverage. The new affordability rule for related individuals does not change the availability of any current coverage options for individuals, nor does it change any aspect of those coverage options. Specifically, family members of employees for whom a PTC may now be allowed as a result of the new affordability rule are free to retain their current coverage, or continue to go without coverage, based on their particular circumstances. Because the coverage decision is voluntary, families who would have enrolled in employer coverage will likely enroll in the Exchange if they expect the benefit of split coverage exceeds the monetary or other cost. As detailed in the Special Analyses section of this preamble, the Treasury Department and the IRS expect that only a limited number of families—relative to the population enrolled in employer coverage and relative to those newly eligible for the PTC—will choose to shift their coverage. Only family members for whom it is advantageous, based on their personal and family circumstances, will choose to shift their coverage.

Further, the Treasury Department and the IRS disagree with commenters who suggest that Exchange coverage is necessarily inferior to employer plans. The cost and quality of employer coverage compared to Exchange coverage will depend on what plans are available to the family and the family’s particular circumstances. The Treasury Department and the IRS agree, however, that individuals and families could face new, more complex choices under the new rules as they navigate multiple plan choices, including the choice to enroll in split coverage. Individuals and families will need to assess their current situation and determine whether they want to enroll family members in Exchange coverage with a PTC or in an available employer plan. In comparing their options, these families will need to consider the factors noted by the commenters, including the cost of premiums, the amount of deductibles, the available networks, and the actuarial value of the plans, as well as the various trade-offs if the family is considering split coverage. The Treasury Department and the IRS understand these concerns and are working closely with HHS to ensure that individuals and families have clear and accurate information about the new rules so they can make informed decisions about their health coverage and choose their optimal health coverage. Accordingly, as further explained in section V of this Summary of Comments and Explanation of Revisions, the Treasury Department and the IRS have been working with HHS, and will continue to work with HHS, to ensure that information about the new rules is provided in an accessible fashion to individuals both generally and as part of the Exchange application. In addition, HHS, the Treasury Department, and the IRS encourage individuals to work with agents, brokers, and other assisters when applying for Exchange coverage, whether applying through an Exchange using the Federal eligibility and enrollment platform or a State Exchange using its own platform. Those agents, brokers, and other assisters can help families understand their health coverage options and help them determine which option will best meet their particular needs. The Treasury Department and the IRS also encourage employers to provide employees with resources published by HHS, the Treasury Department, and the IRS relating to the new rules.

C. Effect of New Rules on States

A few commenters asserted that states will face adverse consequences because family members who seek Exchange

coverage under the new affordability rule for related individuals may find instead that they qualify for Medicaid or the Children’s Health Insurance Program (CHIP). The commenters asserted that people may switch from employer coverage, where states bear no cost, to public programs, the most significant items on state budgets, which will impose new burdens on states. Some of these commenters stated that the new affordability rule will increase costs on state Medicaid programs by increasing the number of people who apply for coverage through the Exchange and then enroll in Medicaid. These commenters cited an analysis by the Urban Institute estimating that 90,000 family members—mainly children—would newly enroll in Medicaid or CHIP owing to their parents seeking Exchange coverage.⁵⁴ The Treasury Department and the IRS did not receive comments from any states expressing concern about potential adverse consequences.

As an initial matter, the Treasury Department and the IRS note that Congressional legislation established the Medicaid and CHIP programs prior to, and independent of, the ACA and these final regulations. States have knowingly and consistently elected to participate in the Medicaid and CHIP programs since these programs were adopted. These final regulations have no effect on the Federal standards for those programs, nor do they affect how states determine eligibility for enrollment in their Medicaid or CHIP programs.⁵⁵ The Federal government provides the majority of the funding for State Medicaid and CHIP programs. (The exact share varies based on factors such as the state’s economic characteristics and the types of beneficiaries who enroll.) In general, states pay no more than half of the costs of additional children who enroll in these programs. Additionally, per capita costs to insure children in these programs are substantially lower than costs for adults.

In addition, despite the commenters’ assertions that the final regulations will increase costs to states by increasing enrollment in state programs, the Treasury Department and the IRS view these effects as highly uncertain. Any changes in Medicaid or CHIP enrollment would be second-order

⁵⁴ See Changing the “Family Glitch” Would Make Health Coverage More Affordable for Many Families | Urban Institute.

⁵⁵ Although the Federal government imposes certain mandatory coverage requirements, states primarily determine eligibility standards for these programs. See <https://crsreports.congress.gov/product/pdf/R/R43357/16> and <https://crsreports.congress.gov/product/pdf/R/R43949/19>.

effects that would not stem from changes in Medicaid or CHIP eligibility. Although it is possible the rule may indirectly lead to higher state Medicaid or CHIP spending, there are other factors that will reduce costs for state and local governments. In particular, the analysis cited by the commenters finds that over 75 percent of states' higher Medicaid and CHIP costs will be offset by less spending on uncompensated care for the uninsured. The study projects the potential "tiny" increase in state spending would also be at least partially offset by additional tax revenue.⁵⁶

Because employers are assumed to hold total compensation constant, the Federal government is projected to receive more tax revenue as employers shift compensation from health coverage towards taxable wages; states may receive more tax revenue for the same reason. The combined effect of increased state tax revenue and decreased spending on uncompensated care may completely offset any increase in Medicaid spending. Research has shown that Medicaid expansions under the ACA increased hospital revenue and reduced spending on locally-funded safety net programs, and it is likely that any increase in enrollment in Medicaid and CHIP enrollment that indirectly arises from the rule would have similar effects.⁵⁷ Over the long-term, Medicaid and CHIP beneficiaries may also have higher earnings and pay more in taxes.⁵⁸ Although it is difficult to quantify the combined effect of these factors on state and local budgets, the Treasury Department and the IRS expect any net impact (whether positive or negative) to be small relative to states' total Medicaid spending.⁵⁹

One commenter asserted that Medicaid and CHIP are associated with narrow networks of medical providers, making it harder for families to find pediatricians and other primary care physicians, dentists, and medical specialists. The Treasury Department and the IRS again note that the final regulations do not require individuals to enroll in any particular type of coverage.

⁵⁶ See https://www.urban.org/sites/default/files/publication/104223/changing-the-family-glitch-would-make-health-coverage-more-affordable-for-many-families_1.pdf at pg. 12.

⁵⁷ <https://www.aeaweb.org/articles?id=10.1257/pol.20190279>.

⁵⁸ <https://academic.oup.com/restud/article/87/2/792/5538992?login=false>.

⁵⁹ For context, as of May 2022, there were nearly 89 million individuals enrolled in Medicaid or CHIP. The change of 90,000 people predicted by the Urban Institute analysis is a change of 0.1 percent. See <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2022-medicaid-chip-enrollment-trend-snapshot.pdf>.

Family members who currently are enrolled in an employer plan and are determined eligible for Medicaid or CHIP when they apply for Exchange coverage are not required to leave the employer plan and enroll in Medicaid or CHIP. These family members always have a choice to stay in the employer plan if they prefer the network of medical providers or other aspects of the employer plan to what is provided under Medicaid or CHIP.

IX. Comments Exceeding Scope of Final Regulations

A number of commenters submitted comments on matters not within the purview of the Treasury Department and the IRS. For example, several commenters suggested that the U.S. adopt a Medicare-for-all style of health coverage or offer universal health coverage in a manner similar to the health coverage provided by other countries. Other commenters requested that coverage rules be changed so that children over age 25 could remain enrolled on a parent's health insurance policies, while others recommended that health care providers be required to accept Medicare and Medicaid insurance. These comments are outside the scope of matters handled by the Treasury Department and the IRS and thus are not addressed in the final regulations.

X. Severability

If any provision in this rulemaking is held to be invalid or unenforceable facially, or as applied to any person or circumstance, it shall be severable from the remainder of this rulemaking, and shall not affect the remainder thereof, or the application of the provision to other persons not similarly situated or to other dissimilar circumstances.

Special Analyses

I. Regulatory Planning and Review—Economic Analysis

E.Os 12866 and 13563 direct agencies to assess costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

These final regulations have been designated as subject to review under E.O. 12866 pursuant to the 2018 MOA between the Treasury Department and

OMB regarding review of tax regulations.

A. Background

1. Affordability of Employer Coverage for Family Members of an Employee

As noted earlier in this preamble, section 36B provides a PTC for applicable taxpayers who meet certain eligibility requirements, including that the taxpayer or one or more family members is enrolled in a QHP for one or more months in which they are not eligible for other MEC. However, an individual who is eligible to enroll in employer coverage, but chooses not to, is not considered eligible for the employer coverage if it is "unaffordable." Section 36B defines employer coverage as unaffordable for an employee if the employee's share of the self-only premium is more than 9.5 percent of the employee's household income.

Section 1.36B-2(c)(3)(v)(A)(2) provides that affordability of employer coverage for each related individual of the employee is determined by the cost of self-only coverage. Thus, the employee and any related individuals included in the employee's family, within the meaning of § 1.36B-1(d), are eligible for MEC and are ineligible for the PTC if (1) the plan provides minimum value and (2) the employee's share of the self-only coverage is not more than 9.5 percent of household income (that is, the self-only coverage for the employee is "affordable").

2. Description of the Final Regulations

The final regulations revise § 1.36B-2(c)(3)(v)(A)(2) to provide a separate affordability test for related individuals based on the cost to the employee of family coverage. The final regulations do not change the affordability test for the employee. When a family applies for Exchange coverage, the Exchange will ask for information concerning which of the family members are offered coverage by their own employer, and the family members to whom the employer's coverage offer extends. When an applicant for whom APTC is otherwise allowed indicates that their employer offers them coverage, the Exchange will ask for the premium for self-only coverage for the applicant and make an affordability determination for the applicant on that basis. When an applicant for whom APTC is otherwise allowed indicates an offer of coverage through an employer of another family member, the Exchange will ask for the premium for family coverage and make an affordability determination for the applicant on that basis. It is therefore

possible that family members would be eligible for APTC but the employee would not. In this case, if the entire family chooses to enroll in Exchange coverage with APTC, the APTC would be paid only for coverage of the employee's family members but would not be paid for coverage of the employee.

B. Baseline

The Treasury Department and the IRS have assessed the benefits and costs of the final regulations relative to a no-action baseline reflecting anticipated Federal income tax-related behavior in the absence of these regulations.

C. Affected Entities

Some families with an offer of employer coverage to the employee and at least one other family member would be newly eligible for the PTC for the Exchange coverage of the non-employee family members. The final regulations will have no effect on families for whom self-only employer coverage costs more than 9.5 percent of household income—as family coverage is more expensive than self-only coverage—because the affordability status of their employer coverage is unchanged. Similarly, the final regulations will not affect families for whom the cost of family employer coverage does not exceed 9.5 percent of household income because their coverage is determined to be affordable either way. In contrast, the final regulations will affect only family members—other than the employee—for whom the employee's cost for the available employer coverage does not exceed 9.5 percent of household income for a self-only plan but does exceed 9.5 percent of household income for a family plan or for whom the offer of the family plan is affordable but does not provide minimum value.

Employers may see some of their employees shift from family coverage to self-only coverage when family members newly qualify for the PTC. The cost per enrollee could increase or decrease depending on the characteristics of those that remain covered. However, this shift will likely lead to a small decrease in the total amount employers are spending on health coverage—due to covering fewer total people—as the Federal government increases spending on PTC for the non-employee family members who move from employer coverage to Exchange coverage.

D. Economic Analysis of the Final Regulations

1. Overview

For some families, the final regulations will lower the premium contributions required to purchase coverage for all family members by allowing family members other than the employee to receive a PTC. For some families with offers of employer coverage who will be newly eligible for the PTC, the combined cost of split coverage (self-only employer coverage for the employee plus PTC-subsidized Exchange coverage for related individuals) will be lower than what they pay for family coverage through the employer. Some low-income families with uninsured individuals where the employee is offered low-cost, self-only employer coverage and relatively high-cost family employer coverage will gain access to a lower-cost option through eligibility for the PTC on behalf of one or more related individuals.

However, the cost for families to purchase Exchange coverage with PTC is determined in part by the applicable percentage and household income, which are the same regardless of the number of individuals actually covered. Therefore, if the number of individuals needing Exchange coverage is small—such as when some family members have access to other MEC—the cost of Exchange coverage per enrollee is relatively high when added to the cost of the employee share of self-only employer coverage. Furthermore, split coverage also means multiple deductibles and maximum out-of-pocket limits for the family, which potentially increases out-of-pocket costs for families. As a result of these features, many families with offers of employer coverage who will be newly eligible for the PTC under the final regulations—including families with some uninsured individuals—would not see any savings in the combined cost of out-of-pocket premiums and cost sharing. Lastly, many families may prefer the benefits and provider networks of employer coverage, compared to Exchange coverage.

Taking all these factors into account, the Treasury Department and the IRS expect new take-up of Exchange coverage may be modest relative to the size of the newly eligible population and relative to the total number of individuals who are either uninsured or covered by employer coverage because many will either still prefer employer coverage or prefer to purchase other goods and services, or save or invest, rather than insure all family members.

The Office of Tax Analysis has evaluated the effect of the policy change on health insurance coverage decisions and the Federal deficit. The policy change is predicted to increase the number of individuals with PTC-subsidized Exchange coverage by approximately 1 million and increase the Federal deficit by an average of \$3.8 billion per year over the next 10 years. The deficit increases as enrollment in PTC-subsidized Exchange coverage increases, offset by a modest decrease in the tax exclusion for employer coverage.⁶⁰ These changes to the revenue effect associated with the PTC as well as the tax exclusion for employer coverage are transfer payments. Transfer payments are neither a cost nor a benefit. The analysis relied on tax data as well as the Medical Expenditure Panel Survey. The Medical Expenditure Panel Survey dataset includes several variables that are not observed in the tax data such as employee contribution amounts for family coverage as well as health care utilization.

2. Benefits

Gain of health insurance coverage. For those individuals who are uninsured because the premiums for family coverage through a family member's employer are unaffordable, gaining access to the PTC for the purchase of Exchange coverage may make coverage more affordable and may prompt some of them to take up coverage.

Additional health insurance option. For those individuals who are covered by family coverage through a family member's employer that costs more than 9.5 percent of their household income, the final regulations will, by providing access to a PTC, give them an additional option that could provide coverage at a lower cost or with more comprehensive benefits.

3. Costs

Administrative costs. Adding this new option for eligibility for PTC increases the cost to the IRS to evaluate PTC claims. The IRS's PTC infrastructure will require one-time changes to certain processes, forms, and instructions to be implemented in time for the 2023 taxable year, and the cost of these changes is expected to be negligible. The Centers for Medicare & Medicaid Services (CMS), as the administrator of

⁶⁰The predictions rely on various assumptions including, but not limited to, the economic and technical assumptions from the 2023 Mid-Session Review. The assumptions are based on the current law baseline as of August 31, 2022. The baseline includes the PTC changes enacted under the IRA.

the Federally-facilitated Exchanges and the Federal Exchange eligibility and enrollment platform, and the State Exchanges that operate their own Exchange eligibility and enrollment platforms will also incur administrative costs as the Exchanges will have primary responsibility for implementing the rule as part of the eligibility and enrollment process when families are applying for Exchange coverage with APTC. Exchanges will incur one-time costs to update Exchange eligibility systems to account for the new treatment of family contribution amounts for employer coverage for purposes of determining eligibility for APTC. In addition, CMS, State Exchanges, State Medicaid Agencies, and CMS-approved Enhanced Direct Enrollment partners will incur administrative costs to make conforming updates to their respective consumer applications and consumer-facing affordability tools. The Treasury Department and the IRS anticipate total administrative costs to CMS, the Exchanges, State Medicaid Agencies, and Enhanced Direct Enrollment partners associated with the final regulation to be modest.

The Treasury Department and the IRS do not expect any new administrative costs for employers because the final regulations do not impose new reporting requirements. Under current regulations, ALEs must report the cost of self-only coverage on Form 1095-C. The primary purpose of this reporting is to collect information relevant for the administration of the employer shared responsibility provisions in section 4980H. Because the cost of family coverage is not relevant for computing the employer shared responsibility payment, the final regulations do not require ALEs to report the cost of family coverage on Form 1095-C. Further, as noted earlier in this preamble, these final regulations do not amend the regulations under section 6055 or 6056, and the IRS does not intend to revise Form 1095-B or Form 1095-C to require any additional data elements related to the new rules.

4. Transfer Payments

Increased PTC costs for new Exchange enrollees. Because some individuals may be newly eligible for the PTC, some individuals may move from employer coverage or uninsured status to Exchange coverage. Thus, the final regulations may increase the amount of PTC being paid by the government and reduce employer contributions.

Decreased employer exclusion for people who drop employer coverage. If individuals drop their employer

coverage, or do not enroll when they otherwise would have, to take up Exchange coverage, the amount of money that was going toward their employer coverage, which provides tax-preferred health benefits, will go into the employee's wages, other employees' wages, and/or employer profits and will no longer be tax exempt. Thus, the final regulations may increase the amount of tax revenue received from income and payroll taxes.

II. Paperwork Reduction Act

This final rule does not include information collections under the Paperwork Reduction Act (5 U.S.C. chapter 35).

III. Regulatory Flexibility Act

It is hereby certified that these final regulations will not have a significant economic impact on a substantial number of small entities within the meaning of section 601(6) of the Regulatory Flexibility Act (5 U.S.C. chapter 6).

As mentioned in the response to commenters, the Treasury Department and the IRS hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the majority of the effect of the final regulations falls on individual taxpayers, and entities will experience only small changes.

Pursuant to section 7805(f) of the Code, these final regulations were submitted to the Chief Counsel for the Office of Advocacy of the Small Business Administration for comment on their impact on small business, and no comments were received.

IV. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditures in any one year by a state, local, or tribal government, in the aggregate, or by the private sector, of \$100 million (updated annually for inflation). This rule does not include any Federal mandate that may result in expenditures by state, local, or tribal governments, or by the private sector in excess of that threshold.

V. Executive Order 13132: Federalism

E.O. 13132 (Federalism) prohibits an agency from publishing any rule that has Federalism implications if the rule either imposes substantial, direct compliance costs on state and local

governments, and is not required by statute, or preempts state law, unless the agency meets the consultation and funding requirements of section 6 of the E.O. This rule does not have Federalism implications and does not impose substantial direct compliance costs on state and local governments or preempt state law within the meaning of the E.O.

VI. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as a major rule as defined by 5 U.S.C. 804(2).

Statement of Availability of IRS Documents

Guidance cited in this preamble is published in the Internal Revenue Bulletin and is available from the Superintendent of Documents, U.S. Government Publishing Office, Washington, DC 20402, or by visiting the IRS website at <https://www.irs.gov>.

Drafting Information

The principal author of these regulations is Clara L. Raymond of the Office of Associate Chief Counsel (Income Tax and Accounting). However, other personnel from the Treasury Department and the IRS participated in the development of these regulations.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, the Treasury Department and the IRS amend 26 CFR part 1 as follows:

PART 1—INCOME TAXES

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

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

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

- a. Adding an entry for § 1.36B–2(c)(3)(v)(A)(8);
- b. Adding entries for § 1.36B–6(a)(1) and (2) and (a)(2)(i) and (ii); and
- c. Revising the entry for § 1.36B–6(g)(2).

The additions and revisions read as follows:

§ 1.36B–0 Table of contents.

* * * * *

§ 1.36B–2 Eligibility for premium tax credit.

* * * * *

(c) * * *
 (3) * * *
 (v) * * *
 (A) * * *
 (8) Multiple offers of coverage.
 * * * * *

§ 1.36B–6 Premium tax credit definitions.

(a) * * *
 (1) Employees.
 (2) Related individuals
 (i) In general.
 (ii) Plans providing MV to employees.
 * * * * *

(g) * * *
 (2) Exceptions.

- **Par. 3.** Section 1.36B–2 is amended by:
 - a. Revising the first sentence and adding a new second sentence in paragraph (c)(3)(v)(A)(2).
 - b. Adding paragraph (c)(3)(v)(A)(8).
 - c. Revising the second sentence of paragraph (c)(3)(v)(B).
 - d. In paragraph (c)(3)(v)(D), Examples 1 through 9 are designated as paragraphs (c)(3)(v)(D)(1) through (9), respectively.
 - e. In newly designated paragraphs (c)(3)(v)(D)(3), (5), (6), (7), and (9), redesignating the paragraphs in the first column as the paragraphs in the second column:

Old paragraphs	New paragraphs
(c)(3)(v)(D)(3)(i) through (ii).	(c)(3)(v)(D)(3)(i) through (ii)
(c)(3)(v)(D)(5)(i) through (ii).	(c)(3)(v)(D)(5)(i) through (ii)
(c)(3)(v)(D)(6)(i) through (ii).	(c)(3)(v)(D)(6)(i) through (ii)
(c)(3)(v)(D)(7)(i) through (iv).	(c)(3)(v)(D)(7)(i) through (iv)
(c)(3)(v)(D)(9)(i) through (ii).	(c)(3)(v)(D)(9)(i) through (ii)

- f. Revising newly redesignated paragraphs (c)(3)(v)(D)(1) and (2).
- g. Redesignating paragraphs (c)(3)(v)(D)(3) through (9) as paragraphs (c)(3)(v)(D)(7) through (13), respectively.
- h. Adding new paragraphs (c)(3)(v)(D)(3) through (6).
- i. Revising the heading for newly redesignated paragraph (c)(3)(v)(D)(7), the heading and first sentence of newly redesignated paragraph (c)(3)(v)(D)(8), the heading of newly redesignated paragraph (c)(3)(v)(D)(9), and the first sentence of newly redesignated paragraph (c)(3)(v)(D)(9)(i).
- j. In the headings for newly redesignated paragraphs (c)(3)(v)(D)(10) through (13), removing the first period and adding a colon in its place.
- k. Revising paragraph (e)(1).
- l. Adding paragraph (e)(5).

The revisions and additions read as follows:

§ 1.36B–2 Eligibility for premium tax credit.

* * * * *
 (c) * * *
 (3) * * *
 (v) * * *
 (A) * * *

(2) * * * Except as provided in paragraph (c)(3)(v)(A)(3) of this section, an eligible employer-sponsored plan is affordable for a related individual if the employee's required contribution for family coverage under the plan does not exceed the required contribution percentage, as defined in paragraph (c)(3)(v)(C) of this section, of the applicable taxpayer's household income for the taxable year. For purposes of this paragraph (c)(3)(v)(A)(2), an employee's required contribution for family coverage is the portion of the annual premium the employee must pay for coverage of the employee and all other individuals included in the employee's family, as defined in § 1.36B–1(d), who are offered coverage under the eligible employer-sponsored plan. * * *

(8) *Multiple offers of coverage.* An individual who has offers of coverage under eligible employer-sponsored plans from multiple employers, either as an employee or a related individual, has an offer of affordable coverage if at least one of the offers of coverage is affordable under paragraph (c)(3)(v)(A)(1) or (2) of this section.

(B) * * * 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 an 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 applicable taxpayer's household income for the taxable year. * * *

(D) * * *

(1) *Example 1: Basic determination of affordability.* For all of 2023, taxpayer C works for an employer, X, that offers its employees and their spouses a health insurance plan under which, to enroll in self-only coverage, C must contribute an amount for 2023 that does not exceed the required contribution percentage of C's 2023 household income. Because C's required contribution for self-only coverage does not exceed the required contribution percentage of C's household income, under paragraph (c)(3)(v)(A)(1) of this section, X's plan is affordable for C, and C is eligible for minimum essential coverage for all months in 2023.

(2) *Example 2: Basic determination of affordability for a related individual.* (i)

The facts are the same as in paragraph (c)(3)(v)(D)(1) of this section (Example 1), except that C is married to J, they file a joint return, and to enroll C and J, X's plan requires C to contribute an amount for coverage for C and J for 2023 that exceeds the required contribution percentage of C's and J's household income. J does not work for an employer that offers employer-sponsored coverage.

(ii) J is a member of C's family as defined in § 1.36B–1(d). Because C's required contribution for coverage of C and J exceeds the required contribution percentage of C's and J's household income, under paragraph (c)(3)(v)(A)(2) of this section, X's plan is unaffordable for J. Accordingly, J is not eligible for minimum essential coverage for 2023. However, under paragraph (c)(3)(v)(A)(1) of this section, X's plan is affordable for C, and C is eligible for minimum essential coverage for all months in 2023.

(3) *Example 3: Multiple offers of coverage.* The facts are the same as in paragraph (c)(3)(v)(D)(2) of this section (Example 2), except that J works all year for an employer that offers employer-sponsored coverage to employees. J's required contribution for the cost of self-only coverage from J's employer does not exceed the required contribution percentage of C's and J's household income. Although the coverage offered by C's employer for C and J is unaffordable for J, the coverage offered by J's employer is affordable for J. Consequently, under paragraphs (c)(3)(v)(A)(1) and (8) of this section, J is eligible for minimum essential coverage for all months in 2023.

(4) *Example 4: Cost of covering individuals not part of taxpayer's family.* (i) D and E are married, file a joint return, and have two children, F and G, under age 26. F is a dependent of D and E, but G is not. D works all year for an employer that offers employer-sponsored coverage to employees, their spouses, and their children under age 26. E, F, and G do not work for employers offering coverage. D's required contribution for self-only coverage under D's employer's coverage does not exceed the required contribution percentage of D's and E's household income. D's required contribution for coverage of D, E, F, and G exceeds the required contribution percentage of D's and E's household income, but D's required contribution for coverage of D, E, and F does not exceed the required contribution percentage of the household income.

(ii) E and F are members of D's family as defined in § 1.36B–1(d). G is not a member of D's family under § 1.36B–

1(d), because G is not D's dependent. Under paragraph (c)(3)(v)(A)(1) of this section, D's employer's coverage is affordable for D because D's required contribution for self-only coverage does not exceed the required contribution percentage of D's and E's household income. D's employer's coverage also is affordable for E and F, because, under paragraph (c)(3)(v)(A)(2) of this section, D's required contribution for coverage of D, E, and F does not exceed the required contribution percentage of D's and E's household income. Although D's cost to cover D, E, F, and G exceeds the required contribution percentage of D's and E's household income, under paragraph (c)(3)(v)(A)(2) of this section, the cost to cover G is not considered in determining whether D's employer's coverage is affordable for E and F, regardless of whether G actually enrolls in the plan, because G is not in D's family. D, E, and F are eligible for minimum essential coverage for all months in 2023. Under paragraph (c)(4)(i) of this section, G is considered eligible for the coverage offered by D's employer only if G enrolls in the coverage.

(5) *Example 5: More than one family member with an employer offering coverage.* (i) K and L are married, file a joint return, and have one dependent child, M. K works all year for an employer that offers coverage to employees, spouses, and children under age 26. L works all year for an employer that offers coverage to employees only. K's required contribution for self-only coverage under K's employer's coverage does not exceed the required contribution percentage of K's and L's household income. Likewise, L's required contribution for self-only coverage under L's employer's coverage does not exceed the required contribution percentage of K's and L's household income. However, K's required contribution for coverage of K, L, and M exceeds the required contribution percentage of K's and L's household income.

(ii) L and M are members of K's family as defined in § 1.36B-1(d). Under paragraph (c)(3)(v)(A)(1) of this section, K's employer's coverage is affordable for K because K's required contribution for self-only coverage does not exceed the required contribution percentage of K's and L's household income. Similarly, L's employer's coverage is affordable for L, because L's required contribution for self-only coverage does not exceed the required contribution percentage of K's and L's household income. Thus, K and L are eligible for minimum essential coverage for all months in 2023. However, under paragraph

(c)(3)(v)(A)(2) of this section, K's employer's coverage is unaffordable for M, because K's required contribution for coverage of K, L, and M exceeds the required contribution percentage of K's and L's household income. Accordingly, M is not eligible for minimum essential coverage for 2023.

(6) *Example 6: Multiple offers of coverage for a related individual.* (i) The facts are the same as in paragraph (c)(3)(v)(D)(5) of this section (Example 5), except that L works all year for an employer that offers coverage to employees, spouses, and children under age 26. L's required contribution for coverage of K, L, and M does not exceed the required contribution percentage of K's and L's household income.

(ii) Although M is not eligible for affordable employer coverage under K's employer's coverage, paragraph (c)(3)(v)(A)(8) of this section dictates that L's employer coverage must be evaluated to determine whether L's employer coverage is affordable for M. Under paragraph (c)(3)(v)(A)(2) of this section, L's employer's coverage is affordable for M, because L's required contribution for K, L, and M does not exceed the required contribution percentage of K's and L's household income. Accordingly, M is eligible for minimum essential coverage for all months in 2023.

(7) *Example 7: Determination of unaffordability at enrollment.* * * *

(8) *Example 8: Determination of unaffordability for plan year.* The facts are the same as in paragraph (c)(3)(v)(D)(7) of this section (Example 7), except that X's employee health insurance plan year is September 1 to August 31. * * *

(9) *Example 9: No affordability information affirmatively provided for annual redetermination.* (i) The facts are the same as in paragraph (c)(3)(v)(D)(7) of this section (Example 7), except the Exchange redetermines D's eligibility for advance credit payments for 2015.
* * *

* * * * *
(e) * * *

(1) Except as provided in paragraphs (e)(2) through (5) of this section, this section applies to taxable years ending after December 31, 2013.
* * * * *

(5) The first two sentences of paragraph (c)(3)(v)(A)(2), paragraph (c)(3)(v)(A)(8), the second sentence of paragraph (c)(3)(v)(B), paragraphs (c)(3)(v)(D)(1) through (6), and the first sentences of paragraphs (c)(3)(v)(D)(8) and (9) of this section apply to taxable years beginning after December 31, 2022.

■ **Par. 4.** Section 1.36B-3 is amended by revising paragraphs (d)(1)(i) and (n)(1) and adding paragraph (n)(3) to read as follows:

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

* * * * *

(d) * * *

(1) * * *

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

* * * * *

(n) * * *

(1) Except as provided in paragraphs (n)(2) and (3) of this section, this section applies to taxable years ending after December 31, 2013.

* * * * *

(3) Paragraph (d)(1)(i) of this section applies to taxable years beginning after December 31, 2022.

■ **Par. 5.** Section 1.36B-6 is amended by revising paragraphs (a) and (g)(2) to read as follows:

§ 1.36B-6 Minimum value.

(a) *In general—(1) Employees.* An eligible employer-sponsored plan provides minimum value (MV) for an employee of the employer offering the coverage only if—

(i) The plan's MV percentage, as defined in paragraph (c) of this section, is at least 60 percent based on the plan's share of the total allowed costs of benefits provided to the employee; and

(ii) The plan provides substantial coverage of inpatient hospital services and physician services.

(2) *Related individuals—(i) In general.* An eligible employer-sponsored plan provides MV for an individual who may enroll in the plan because of a relationship to an employee of the employer offering the coverage (a related individual) only if—

(A) The plan's MV percentage, as defined in paragraph (c) of this section, is at least 60 percent based on the plan's share of the total allowed costs of benefits provided to the related individual; and

(B) The plan provides substantial coverage of inpatient hospital services and physician services.

(ii) *Plans providing MV to employees.* If an eligible employer-sponsored plan provides MV to an employee under paragraph (a)(1) of this section, the plan also provides MV for related individuals if—

(A) The scope of benefits is the same for the employee and related individuals; and

(B) Cost sharing (including deductibles, co-payments, coinsurance, and out-of-pocket maximums) under the plan is the same for the employee and related individuals under the tier of coverage that would, if elected, include the employee and all related individuals (disregarding any differences in deductibles or out-of-pocket maximums that are attributable to a different tier of coverage, such as self plus one versus family coverage).

* * * *

(g) * * *

(2) *Exceptions.* (i) Paragraph (a)(1)(ii) of this section applies for plan years beginning after November 3, 2014; and

(ii) Paragraph (a)(2) of this section applies to taxable years beginning after December 31, 2022.

Douglas W. O'Donnell,

Deputy Commissioner for Services and Enforcement.

Approved: October 1, 2022.

Lily Batchelder,

Assistant Secretary of the Treasury (Tax Policy).

[FR Doc. 2022-22184 Filed 10-11-22; 8:45 am]

BILLING CODE 4830-01-P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

31 CFR Part 560

Publication of Iranian Transactions and Sanctions Regulations Web General License D-2

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Publication of a web general license.

SUMMARY: The Department of the Treasury's Office of Foreign Assets Control (OFAC) is publishing one general license (GL) issued pursuant to the Iranian Transactions and Sanctions Regulations: GL D-2, which was previously made available on OFAC's website.

DATES: GL D-2 was issued on September 23, 2022. See **SUPPLEMENTARY INFORMATION** for additional relevant dates.

FOR FURTHER INFORMATION CONTACT: OFAC: Assistant Director for Licensing, 202-622-2480; Assistant Director for Regulatory Affairs, 202-622-4855; or Assistant Director for Sanctions Compliance & Evaluation, 202-622-2490.

SUPPLEMENTARY INFORMATION:

Electronic Availability

This document and additional information concerning OFAC are available on OFAC's website: www.treas.gov/ofac.

Background

On September 23, 2022, OFAC issued GL D-2 to authorize certain transactions otherwise prohibited by the Iranian Transactions and Sanctions Regulations, 31 CFR part 560. At the time of issuance, OFAC made GL D-2 available on its website (www.treas.gov/ofac). GL D-2 replaced and superseded GL D-1 in its entirety. The text of GL D-2 is provided below.

OFFICE OF FOREIGN ASSETS CONTROL

Iranian Transactions and Sanctions Regulations

31 CFR part 560

GENERAL LICENSE D-2

General License With Respect to Certain Services, Software, and Hardware Incident to Communications

(a) To the extent that such transactions are not exempt from the prohibitions of the Iranian Transactions and Sanctions Regulations, 31 CFR part 560 (ITSR), and subject to the restrictions set forth in paragraph (b), the following transactions are authorized:

(1) *Fee-based or no-cost services.* The exportation or reexportation, directly or indirectly, from the United States or by a U.S. person, wherever located, to Iran of fee-based or no-cost services incident to the exchange of communications over the internet, such as instant messaging, chat and email, social networking, sharing of photos and movies, web browsing, blogging, social media platforms, collaboration platforms, video conferencing, e-gaming, e-learning platforms, automated translation, web maps, and user authentication services, as well as cloud-based services in support of the foregoing or of any other transaction authorized or exempt under the ITSR.

(2) *Fee-based or no-cost software.* (i) *Software subject to the EAR.* The exportation, reexportation, or provision, directly or indirectly, to Iran of fee-based or no-cost software subject to the Export Administration Regulations, 15 CFR parts 730 through 774 (EAR), that is incident to, or enables services incident to, the exchange of communications over the internet, such as instant messaging, chat and email, social networking, sharing of photos and

movies, web browsing, blogging, social media platforms, collaboration platforms, video conferencing, e-gaming, e-learning platforms, automated translation, web maps, and user authentication services, as well as cloud-based services in support of the foregoing or of any other transaction authorized or exempt under the ITSR, provided that such software is designated EAR99 or classified by the U.S. Department of Commerce on the Commerce Control List, 15 CFR part 774, supplement No. 1 (CCL), under export control classification number (ECCN) 5D992.c.

(ii) *Software that is not subject to the EAR because it is of foreign origin and is located outside the United States.* The exportation, reexportation, or provision, directly or indirectly, by a U.S. person, wherever located, to Iran of fee-based or no-cost software that is not subject to the EAR because it is of foreign origin and is located outside the United States, that is incident to, or enables services incident to, the exchange of communications over the internet, such as instant messaging, chat and email, social networking, sharing of photos and movies, web browsing, blogging, social media platforms, collaboration platforms, video conferencing, e-gaming, e-learning platforms, automated translation, web maps, and user authentication services, as well as cloud-based services in support of the foregoing or of any other transaction authorized or exempt under the ITSR, provided that such software is designated EAR99 if it were located in the United States or would meet the criteria for classification under ECCN 5D992.c if it were subject to the EAR.

Note to paragraphs (a)(1) and (a)(2). See 31 CFR 560.540 for authorizations relating to the exportation to persons in Iran of additional no-cost services incident to the exchange of personal communications over the internet and no-cost software necessary to enable such services.

(3) *Additional Software, Hardware, and Related Services.* To the extent not authorized by paragraphs (a)(1) or (a)(2) of this general license, the exportation, reexportation, or provision, directly or indirectly, to Iran of certain software and hardware incident to communications, as well as related services, as follows:

(i) In the case of hardware and software subject to the EAR, the items specified in the Annex to this general license;

(ii) In the case of hardware and software that is not subject to the EAR because it is of foreign origin and is located outside the United States that is exported, reexported, or provided,