



DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG-101576-26]

RIN 1545-BS15

Premium Tax Credit

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains proposed regulations that would amend regulations regarding an individual taxpayer's eligibility for a premium tax credit (PTC), the computation of a PTC, and an individual's tax liability due to excess advance payments of the PTC. The proposed regulations would affect taxpayers who enroll themselves or a family member in individual health insurance coverage through a Health Insurance Exchange and may be allowed a PTC for this coverage. This document also provides a notice of a public hearing on these proposed regulations.

DATES: Electronic or written comments must be received by **[INSERT DATE 45 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. A telephonic public hearing on this proposed regulation has been scheduled for December 8, 2026, at 10 a.m. ET. Requests to speak and outlines of topics to be discussed at the public hearing must be received by **[INSERT DATE 45 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. If no outlines are received by **[INSERT DATE 45 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, the public hearing will be cancelled. Requests to attend the public hearing must be received by 5 p.m. ET on December 4, 2026.

ADDRESSES: Commenters are strongly encouraged to submit public comments

electronically. Submit electronic submissions via the Federal eRulemaking Portal at <https://www.regulations.gov> (indicate IRS and REG-101576-26) by following the online instructions for submitting comments. Requests for the public hearing must be submitted as prescribed in the “Comments and Public Hearing” section. Once submitted to the Federal eRulemaking Portal, comments cannot be edited or withdrawn. The Department of the Treasury (Treasury Department) and the IRS will publish for public availability any comments submitted to the IRS’s public docket. Send paper submissions to: CC:PA:01:PR (REG-101576-26), Room 5503, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, D.C. 20044. We encourage commenters to include supporting facts, research, and evidence in their comments. When doing so, commenters are encouraged to provide citations to the published materials referenced, including active hyperlinks. Likewise, commenters who reference materials which have not been published are encouraged to upload relevant data collection instruments, data sets, and detailed findings as a part of their comment. Providing such citations and documentation will assist us in analyzing the comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a summary of not more than 100 words in length of this proposed rule, in plain language, may be found at <https://www.regulations.gov/>.

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Mia Romano at (202) 317-4718; concerning submissions of comments or the public hearing, please contact Publications and Regulations Section at (202) 317-6901 (not toll-free numbers) or by email at publichearings@irs.gov (preferred).

SUPPLEMENTARY INFORMATION:

Authority

This notice of proposed rulemaking contains proposed amendments that would amend the Income Tax Regulations (26 CFR part 1) under section 36B of the Internal

Revenue Code (Code), as amended by sections 71119 and 71301 through 71305 of Public Law 119-21, 139 Stat. 72, 306-315, 321-325, (July 4, 2025), commonly known as the One, Big, Beautiful Bill Act (OBBBA). Section 36B(h) provides an express delegation of authority for the Secretary of the Treasury or the Secretary's delegate (Secretary) to prescribe such regulations as may be necessary to carry out section 36B, including regulations that provide for the coordination of the Premium Tax Credit (PTC) allowed under section 36B with the program for advance payment of the Premium Tax Credit (APTC) under section 1412 of the Affordable Care Act (ACA).¹ The proposed regulations are also issued under the authority of section 7805(a) of the Code, which authorizes the Secretary to prescribe all needful rules and regulations for the enforcement of the Code including all rules and regulations as may be necessary by reason of any alteration of law in relation to internal revenue.

Background

I. Definition of "Qualified Health Plan"

Section 36B provides a PTC to applicable taxpayers who meet certain eligibility requirements, and who enroll, or enroll another member of the applicable taxpayer's family, as defined in § 1.36B-1(d)(1), in a qualified health plan (QHP) through a Health Insurance Exchange (Exchange). Under section 36B(c)(3)(A) and § 1.36B-1(c), the term "qualified health plan" has the same meaning as in section 1301(a) of the Affordable Care Act (42 U.S.C. 18021(a)) but does not include a catastrophic plan described in section 1302(e) of the Affordable Care Act (42 U.S.C. 18022(e)). Individuals must, in general, enroll in a QHP during the open enrollment period for the coverage year, but Exchanges provide special enrollment periods (SEP) for enrollments during a coverage year if certain conditions are met.

¹ The Affordable Care Act refers to the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010).

Section 71303(b) of the OBBBA amends section 36B(c)(3)(A) to provide that, for taxable years beginning after December 31, 2027, the term “qualified health plan” does not include any plan enrolled in through an Exchange that fails to provide a pre-enrollment verification process described in section 36B(c)(3)(A)(ii). Section 71304(a) of the OBBBA further amends section 36B(c)(3)(A) to provide that, for plan years beginning after December 31, 2025, the term “qualified health plan” does not include any plan enrolled in during a SEP described in section 36B(c)(3)(A)(iii) (relating to a SEP based on a change in an individual’s expected household income).

II. Disallowing PTC During Periods of Medicaid Ineligibility Due to Alien Status

Under section 36B(c)(1)(A) and § 1.36B-2(b)(1), a taxpayer is, in general, not an applicable taxpayer eligible for a PTC unless the taxpayer’s household income, as defined in section 36B(d)(2) and § 1.36B-1(e), for the taxable year, is at least 100 percent but not more than 400 percent of the Federal Poverty Level (FPL), as defined in § 1.36B-1(h), for the taxpayer’s family size. Prior to the OBBBA amendments, section 36B(c)(1)(B) treated a taxpayer with household income below 100 percent of the FPL for the taxpayer’s family size as an applicable taxpayer if the taxpayer or a member of the taxpayer’s family was an alien lawfully present in the U.S. and not eligible for the Medicaid program due to immigration status, and the taxpayer met the other applicable taxpayer requirements. Section 71302(a) of the OBBBA removed section 36B(c)(1)(B) effective for taxable years beginning after December 31, 2025. Thus, for taxable years after December 31, 2025, a taxpayer who is a lawfully present alien with household income below 100% of the FPL for the taxpayer’s family size and who is ineligible for Medicaid due to his or her alien status is not eligible for the PTC.

III. Failure to Demonstrate Community Engagement

Under section 36B, a PTC is allowed only for months that are “coverage months” for a taxpayer or a member of the taxpayer’s family. Section 1.36B-3(c)(1)(iii) provides

that a month is not a coverage month for an individual if the individual is eligible for the full calendar month for minimum essential coverage (within the meaning of § 1.36B-2(c)) other than coverage described in section 5000A(f)(1)(C) of the Code (relating to coverage in the individual market). Under section 5000A(f)(1)(A) and § 1.5000A-2, the term “minimum essential coverage” includes coverage under Government-sponsored programs such as Medicaid.

Section 1.36B-2(c)(2)(i) provides that, for purposes of determining whether a month is a coverage month for an individual, an individual generally is considered eligible for Government-sponsored minimum essential coverage if the individual meets the criteria for coverage under a Government-sponsored program described in section 5000A(f)(1)(A) as of the first day of the first full month the individual may receive benefits under the program. Government-sponsored programs typically require individuals who meet the criteria for eligibility under the program to complete certain requirements to receive benefits under the program. Under § 1.36B-2(c)(2)(ii), an individual who fails, by the last day of the third full calendar month following the event that establishes eligibility for the Government-sponsored minimum essential coverage, to complete the requirements to obtain that coverage is generally treated as eligible for the coverage as of the first day of the fourth calendar month following the event that establishes eligibility.

Notwithstanding these provisions relating to eligibility for Government-sponsored minimum essential coverage, including Medicaid, § 1.36B-2(c)(2)(v) provides that, in general, an individual is treated as not eligible for Medicaid for a period of coverage under a QHP if, when the individual enrolls in the QHP, an Exchange conducts an eligibility determination or assessment (within the meaning of 45 CFR 155.302(b)) and determines or assesses the individual to be not eligible for Medicaid. However, § 1.36B-2(c)(2)(v) also provides that this rule does not apply for an individual who, with

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

Under the section 36B regulations, a reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. Likewise, a disregard of the facts is intentional if the taxpayer knows that information provided to the Exchange is inaccurate. *See, e.g.,* § 1.36B-2(c)(2)(v).

Section 71119(a) of the OBBBA added subsection (xx) to section 1902 of the Social Security Act (42 U.S.C. 1396a) relating to an individual's eligibility for medical assistance under a State plan (or waiver of such plan) under title XIX of the Social Security Act (commonly referred to as the Medicaid statute). In general, section 1902(xx) of the Social Security Act provides that States must require, as a condition of Medicaid eligibility, that "applicable individuals" (generally, individuals eligible for Medicaid's "adult group" or certain individuals eligible for medical assistance under demonstration programs authorized under section 1115 of the Social Security Act (42 U.S.C. 1315)) demonstrate "community engagement" for at least one month (and up to three consecutive months, as specified by a State) immediately preceding the month during which the applicable individual applies for Medicaid. "Community engagement" is generally defined in section 1902(xx)(2) of the Social Security Act (42 U.S.C. 1396a(xx)(2)) as working not less than 80 hours in a month, completing not less than 80 hours of community service in a month, participating in a work program for not less than 80 hours in a month, being enrolled in an educational program at least half-time, or a combination of these activities adding up to not less than 80 hours a month. Applicable individuals can also demonstrate community engagement by meeting certain income requirements. Once enrolled, applicable individuals are subject to ongoing community

engagement requirements.

Some individuals are either excepted or excluded from community engagement requirements under section 1902(xx) of the Social Security Act (42 U.S.C. 1396a(xx)). States must implement community engagement requirements no later than January 1, 2027, unless the Secretary of the Department of Health and Human Services grants the state a good faith effort exemption to delay implementation under section 1902(xx)(11)(A) of the Social Security Act (42 U.S.C. 1396a(xx)(11)(A)), not to extend beyond December 31, 2028.

For purposes of the definition of coverage month under section 36B(c)(2)(B), section 1902(xx)(7)(B) of the Social Security Act (42 U.S.C. 1396a(xx)(7)(B)) provides that an individual is deemed to be eligible for minimum essential coverage under section 5000A(f)(1)(A)(ii) (the Medicaid program under title XIX of the Social Security Act) for a month if the individual would have been eligible for Medicaid but for a failure to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1).

IV. Definition of Coverage Month

Section 1.36B-3(c)(1) provides that a month is a coverage month for an individual if, (i) as of the first day of the month, the individual is enrolled in a QHP through an Exchange; (ii) the taxpayer pays the taxpayer's share of the enrollment premium by the unextended due date for the taxpayer's income tax return for the taxable year, the full premium for the month is paid by advance credit payments, or the amount of the premium paid (including by advance credit payments) for the month is sufficient to avoid termination of the individual's coverage for that month under one of the scenarios described in § 1.36B-3(c)(4); and (iii) the individual is not eligible for the full calendar month for minimum essential coverage (within the meaning of § 1.36B-2(c)) other than coverage described in section 5000A(f)(1)(C) of the Code (relating to coverage in the individual market).

Section 71303(a) of the OBBBA adds sections 36B(c)(5) and 36B(c)(6) effective for taxable years beginning after December 31, 2027.

Section 36B(c)(5)(A) generally provides that a month is not a coverage month for an individual unless the Exchange through which the individual enrolls in QHP coverage verifies for such month using applicable enrollment information provided or verified by the applicant, the individual's eligibility (i) to enroll in the plan through the Exchange, and (ii) for any APTC for the coverage. Section 36B(c)(5)(B) specifies the applicable enrollment information that Exchanges must verify. This includes, to the extent relevant, household income and family size, whether the individual is an eligible alien, "any health coverage status or eligibility for coverage", and place of residence, along with information not specifically identified in section 36B(c)(5) that the Secretary (in consultation with the Secretary of Health and Human Services) determines to be necessary to the verification prescribed in section 36B(c)(5)(A). Section 36B(c)(5)(E) also allows the Secretary to provide verification waivers for individuals who enroll in a QHP during a SEP based on a change in family size.

Section 36B(c)(6) provides that the term "coverage month" does not include, with respect to any individual covered by a QHP, any month for which the Exchange through which the individual enrolled does not meet the requirements of 45 CFR 155.305(f)(4)(iii), as published in the **Federal Register** on June 25, 2025 (90 FR 27074). These Exchange requirements relate to individuals who fail to reconcile their APTC with the PTC that they are allowed on the tax return for a prior enrollment year and, consequently, are determined ineligible for APTC. The prior enrollment year is the year of QHP coverage for which the Exchange would use tax data to verify household income and family size.

Section 1312 of the Affordable Care Act (42 U.S.C. 18032) provides that an individual is not eligible to enroll in a QHP unless the individual resides in the State that

established the Exchange through which the individual is seeking to enroll. In addition, an individual is not eligible to enroll in a QHP if the individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the U.S., or an alien lawfully present in the U.S. These enrollment eligibility requirements are described in greater detail under 45 CFR 155.305(a).

Sections 1411 and 1412 of the Affordable Care Act (42 U.S.C. 18081 and 18082) in relevant part, require the establishment of a program for determining eligibility for enrolling in a QHP and for APTC.

V. Computation of PTC for Families with Individuals Not Lawfully Present and Individuals Lawfully Present but Not Eligible Aliens

Section 1.36B-3(a) provides that the premium assistance credit amount is the sum of the premium assistance amounts determined under § 1.36B-3(d) for all coverage months for individuals in the taxpayer's family. Under § 1.36B-3(d)(1), the premium assistance amount for a coverage month is the lesser of (i) the enrollment premiums, which are the premiums for the month reduced by any amounts that were refunded or unpaid as of the unextended due date for filing the taxpayer's income tax return for the taxable year, for one or more QHPs in which a taxpayer or a member of the taxpayer's family enrolls; or (ii) the excess of the adjusted monthly premium for the applicable benchmark plan over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year. The adjusted monthly premium for the applicable benchmark plan is defined in § 1.36B-3(e) and the applicable percentage is defined in § 1.36B-3(g).

For taxable years beginning before January 1, 2027, section 36B(e)(1)(A) provides that if one or more individuals in a taxpayer's family (including the taxpayer) are aliens not lawfully present (within the meaning of section 36B(e)(2)), the enrollment premiums and adjusted monthly premiums for the applicable benchmark plan otherwise

taken into account in determining the taxpayer's PTC must be reduced by the portion of such premiums attributable to the individuals who are aliens not lawfully present. In addition, section 36B(e)(1)(B) and § 1.36B-3(l) provide that in determining the taxpayer's applicable percentage, (i) the percentage the taxpayer's household income bears to the FPL for the taxpayer's family size is determined by excluding aliens who are not lawfully present from family size and (ii) by treating household income as equal to the product of the taxpayer's household income and a fraction, the numerator of which is the FPL for the taxpayer's family size determined by excluding aliens who are not lawfully present, and the denominator of which is the FPL for the taxpayer's family size determined by including aliens who are not lawfully present.

Section 71301(a) of the OBBBA amended section 36B(e)(1) to expand the applicability of section 36B(e)(1) to the QHP coverage of individuals in a taxpayer's family (including the taxpayer) who are aliens lawfully present in the U.S. but are not eligible aliens. Section 71301(a) of the OBBBA also adds a definition of the term "eligible alien" to section 36B(e)(2). The OBBBA section 71301 amendments to section 36B are effective for taxable years beginning after December 31, 2026.

VI. Multiple Families Enrolled in One Policy

Section 1.36B-3(h) provides that if a QHP covers more than one family under a single policy, each applicable taxpayer covered by the plan may claim a PTC, if otherwise allowable. In addition, in determining for a month the lesser of the enrollment premiums or the excess of the benchmark plan premium over $\frac{1}{12}$ of the product of household income and the applicable percentage, the enrollment premiums for the month are allocated to each taxpayer in proportion to the premiums for each taxpayer's applicable benchmark plan.

VII. Excess APTC Repayment Limitation

Section 36B(f)(1) provides that, if APTC is paid for the QHP coverage of a

taxpayer or another member of the taxpayer's family, the taxpayer's PTC allowed under section 36B is reduced by the amount of the APTC. Under section 36B(f)(2), if the taxpayer's APTC exceeds the PTC that would have been allowed had no APTC been paid, the taxpayer must increase tax liability for the taxable year of the coverage. For taxable years beginning before January 1, 2026, the tax liability increase was equal to the excess of the APTC over the PTC (excess APTC), unless a repayment limitation in section 36B(f)(2)(B) applied to the taxpayer and the amount of the repayment limitation was less than the excess APTC. This excess APTC repayment limitation is reflected in § 1.36B-4(a)(3)(ii). In addition, § 1.36B-4(a)(3)(iii) provides the excess APTC limitation that must be used by taxpayers who claim a section 162(l) deduction for their QHP premiums. Section 71305 of the OBBBA removed the section 36B(f)(2)(B) repayment limitation for taxable years beginning after December 31, 2025. Thus, for taxable years beginning after December 31, 2025, a taxpayer's tax liability for the taxable year of the coverage is increased by the full amount of the excess APTC.

VIII. Reporting of QHP Information by Exchanges

Section 36B(f)(3) and § 1.36B-5 require Exchanges to report to taxpayers and the IRS certain information relating to QHP enrollment. This information is reported to taxpayers on IRS Form 1095-A, *Health Insurance Marketplace Statement*. The Centers for Medicare & Medicaid Services (CMS), part of the Department of Health and Human Services (HHS), is responsible for the Form 1095-A reporting for Exchanges that use the Federal eligibility and enrollment platform (Federally-facilitated Exchanges, or FFEs, and State-based Exchanges on the Federal platform, or SBE-FPs). States with their own platforms (State-based Exchanges or SBEs) are responsible for the Form 1095-A reporting for individuals who enroll in their State-based Exchange. Among the items Exchanges must report are (i) enrollment premiums for the plan or plans enrolled in (excluding the portion of the premiums allocable to benefits in excess of essential health

benefits), and (ii) for plans for which APTC is paid, the premium for the applicable benchmark plan for purposes of computing advance credit payments and the amount of the advance credit payments.

Explanation of Provisions

The proposed regulations would amend the regulations under section 36B to reflect the amendments to section 36B made by sections 71301 through 71305 of the OBBBA. The proposed regulations would also amend the regulations under section 36B to reflect section 71119(a) of the OBBBA's addition of subsection (xx)(7)(B) to section 1902 of the Social Security Act (42 U.S.C. 1396a) regarding an individual's eligibility for Medicaid for purposes of determining whether a month is a coverage month under section 36B(c)(2)(B).

I. Change to the Definition of "Qualified Health Plan"

To reflect the amended definition of the term "qualified health plan" in section 36B(c)(3)(A) provided by sections 71303(b) and 71304(a) of the OBBBA, the proposed regulations would amend the definition of "qualified health plan" in § 1.36B-1(c). The proposed regulations would provide that the term "qualified health plan" does not include any plan enrolled in through an Exchange if the Exchange fails to provide a pre-enrollment verification process through which an applicant may, beginning not later than August 1 of the year prior to the enrollment year, verify with the Exchange the applicant's household income and eligibility for enrollment in a plan for the plan year beginning in the subsequent year. For the pre-enrollment verification process that Exchanges must provide, see 45 CFR part 155 and any successor or other applicable regulations as may be promulgated.

In addition, the proposed regulations would amend the definition of "qualified health plan" in § 1.36B-1(c) to provide that, for the purposes of section 36B, the term "qualified health plan" does not include any plan enrolled in during a SEP provided by

an Exchange on the basis of the percentage that the individual's expected household income bears to the FPL for the individual's family size (income-based SEP), and not in connection with the occurrence of an event or change in circumstances specified by the Secretary of Health and Human Services for such purposes.

II. Determination of "Applicable Taxpayer"

To reflect the OBBBA's removal of section 36B(c)(1)(B), which allowed a taxpayer with household income less than 100 percent of the FPL for the taxpayer's family size to be treated as an applicable taxpayer if the taxpayer is a lawfully present alien not eligible for the Medicaid program due to immigration status, the proposed regulations would remove the reiteration of that rule in § 1.36B-2(b)(5).

III. Deemed Eligibility for Minimum Essential Coverage When Ineligible for Medicaid Solely Because of Failure to Demonstrate Community Engagement

To reflect section 1902(xx)(7)(B) of the Social Security Act (42 U.S.C. 1396a(xx)(7)(B)), as added by section 71119(a) of the OBBBA, the proposed regulations would amend § 1.36B-2(c)(2)(ii) to provide that an individual who is determined or assessed (within the meaning of 45 CFR 155.302(a) and (b)) by an Exchange to be not eligible for Medicaid solely because the individual failed to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1) is treated as being eligible for minimum essential coverage under section 5000A(f)(1)(A)(ii) as of the first month the individual would have been enrolled in Medicaid but for the failure to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1). See proposed § 1.36B-2(c)(2)(ii)(B). The months the individual was ineligible for Medicaid solely for failing to meet the requirement to demonstrate community engagement would not be coverage months for the individual.

The proposed regulations would also provide that the proposed rule in § 1.36B-2(c)(2)(ii)(B) ceases to apply once the individual is determined or assessed by an

Exchange to be, or becomes, no longer ineligible for Medicaid solely for failing to demonstrate community engagement. See proposed § 1.36B-2(c)(2)(ii)(C). For example, assume a taxpayer in January is determined ineligible for Medicaid solely for failing to meet the requirement to demonstrate community engagement. The taxpayer enrolls in a QHP without APTC and pays all of the premiums for the coverage. In March, the taxpayer's income increases to above the taxpayer's state's Medicaid eligibility income threshold. The taxpayer may be eligible for a PTC beginning in March when the taxpayer's income increases above the taxpayer's state's Medicaid income threshold because the taxpayer has become ineligible for Medicaid for a reason other than failing to meet the requirement to demonstrate community engagement.

For purposes of determining eligibility for a PTC, the proposed regulations would disregard an Exchange's determination or assessment that an individual is no longer ineligible for Medicaid for failing to meet the requirement to demonstrate community engagement if the Exchange's determination or assessment is based on incorrect information provided by the individual with intentional or reckless disregard for the facts. See proposed § 1.36B-2(c)(2)(vi). The proposed regulations would use the same standard for intentional or reckless disregard of the facts as used in the existing regulations.

To reflect section 1902(xx) of the Social Security Act, the proposed regulations would provide that the rule in § 1.36B-2(c)(2)(v)(A), which treats an individual as not eligible for Medicaid for a period of coverage under a QHP if an Exchange determines or assesses the individual to be not eligible for Medicaid, does not apply for individuals determined or assessed by an Exchange to be ineligible for Medicaid, solely for failing to meet the requirement to demonstrate community engagement. See proposed § 1.36B-2(c)(2)(v)(B).

Proposed regulation § 1.36B-2(c)(2)(v)(C) would also provide that, once an

Exchange determines or assesses an individual to be ineligible for Medicaid for a reason other than failing to meet the requirement to demonstrate community engagement, the individual is treated as not eligible for Medicaid for the individual's period of coverage under a QHP and, therefore, those months may be coverage months for the individual. However, proposed regulation § 1.36B-2(c)(2)(vi) would disregard an Exchange's determination or assessment that an individual is ineligible for Medicaid for a reason other than failing to meet the requirement to demonstrate community engagement if the Exchange's determination or assessment is based on incorrect facts provided by the individual with intentional or reckless disregard for the facts.

IV. Changes to the Definition of "Coverage Month"

a. General verification rule

As noted previously, section 71303(a) of the OBBBA, effective for taxable years beginning after December 31, 2027, adds section 36B(c)(5) to provide that a month is not a coverage month for a taxpayer unless the Exchange through which the taxpayer or another member of the taxpayer's family enrolls in QHP coverage, using applicable enrollment information, verifies the individual's eligibility (i) to enroll in the plan through the Exchange, and (ii) for any APTC for the coverage. Because section 36B(c)(5)(A) requires, for coverage month purposes, verification of an individual's eligibility to enroll in a QHP and for any APTC, if relevant, verification is required for any individual for whom a month is to be treated as a coverage month. Therefore, this requirement applies regardless of whether the enrollee requests APTC for their coverage. Exceptions associated with changes in family size are further explained below in section IV.b of this proposed rule.

Section 36B(c)(5)(B)(ii) specifies that applicable enrollment information includes whether an individual is an eligible alien, but section 36B(c)(5)(B) does not expressly identify citizenship, status as a national of the U.S., or lawful presence as applicable

enrollment information. In addition to eligible aliens, U.S. citizens, nationals of the U.S., and other aliens who are lawfully present are also eligible to enroll in a QHP and an Exchange also verifies these statuses for enrollment eligibility. See 42 U.S.C. §§ 18032 and 18081. Accordingly, pursuant to the authority of the Secretary under section 36B(c)(5)(B)(v), in consultation with the HHS Secretary, to require verification of other items deemed necessary, these proposed regulations would provide that information regarding whether an individual is a U.S. citizen, a national of the U.S., or an alien lawfully present in the U.S., is applicable enrollment information necessary to verify eligibility to enroll in a QHP through an Exchange and, if applicable, eligibility for APTC. Consistent with this proposed rule, a month would not be a coverage month for an individual if the Exchange through which the individual enrolled fails to verify the individual's place of residence and that the individual is a U.S. citizen, a national of the U.S., or an alien lawfully present in the U.S.

The proposed regulations would provide that a month may be a coverage month for an individual who does not request APTC if the Exchange verifies only the QHP enrollment eligibility information discussed in the previous paragraph (the individual's place of residence and that the individual is a U.S. citizen, a national of the U.S., or an alien lawfully present in the U.S.). Similarly, a month of enrollment may be a coverage month for an individual who does request APTC but for whom no APTC is paid, provided the Exchange verifies enrollment eligibility information. However, months of enrollment would not be coverage months for an individual if the Exchange is unable to verify an individual's eligibility to enroll in the QHP. For example, if the Exchange enrolls an individual in coverage while verification is pending, but the Exchange is subsequently unable to verify the individual's eligibility to enroll in the QHP, then the months of enrollment before the individual was removed from the coverage would not be coverage months for that individual.

In addition, the proposed regulations would provide that a month for which APTC is paid for an individual is not a coverage month for the individual if the Exchange through which the individual enrolled fails to verify relevant applicable enrollment information. The Treasury Department and the IRS believe the language in section 36B(c)(5)(B) “any health coverage status or eligibility for coverage” is referring to eligibility for minimum essential coverage, other than individual market coverage. This is consistent with the function of section 36B(c)(5)(A), which provides rules regarding when a month is not a coverage month for an individual, and with section 36B(c)(2)(B), under which a month is not a coverage month for an individual if the individual is eligible for minimum essential coverage other than individual market coverage.

Therefore, the proposed regulations would provide that a month for which APTC is paid for an individual is not a coverage month for the individual unless the Exchange through which the individual enrolled verifies all of the following items: the prescribed verification items related to enrollment such as residency, and whether the individual is a U.S. citizen, national of the U.S., or an alien lawfully present in the U.S.; the household income and family size of the taxpayer who is expected to file an income tax return for the year of coverage reconciling the APTC for the individual’s coverage with the PTC allowed for the coverage; whether the individual is eligible for minimum essential coverage, other than individual market coverage; and, if the individual is a lawfully present alien, whether the individual is an eligible alien as defined in section 36B(e)(2)(B). In sum, for a month for which APTC is paid to be a coverage month, the Exchange must verify the applicable enrollment information for both eligibility to enroll in a QHP and eligibility for APTC.

Regarding the verification requirements for Exchanges in section 36B(c)(5), the process Exchanges must follow to verify that an individual is eligible to enroll in a QHP and, if applicable, eligible for APTC for the coverage is provided in section 1411 and

1412 of the Affordable Care Act (42 U.S.C. 18081 and 18082) and the regulations in 45 CFR part 155 subpart D and any successor or other applicable regulations as may be promulgated (collectively, the CMS regulations). The CMS regulations address the process for all individuals, including current enrollees seeking to re-enroll in a QHP and enrollees with a change in circumstances that affects applicable enrollment information during the plan year. If an Exchange follows the process described in the CMS regulations with respect to verifying that an individual is eligible to enroll in a QHP through the Exchange, including the process for an individual's re-enrollment, and verifies the information necessary to establish that the individual is eligible to enroll and, if applicable, eligible for APTC, under the CMS regulations, then section 36B(c)(5) will not cause a month to fail to be a coverage month for the individual.

b. Changes to verified information during a plan year

The Treasury Department and the IRS anticipate that forthcoming CMS proposed regulations would provide that once an Exchange learns of a change in circumstances relating to a QHP enrollee, the Exchange will, in general, seek to verify that information before adjusting the enrollee's current enrollment, including the amount of APTC being paid for the coverage, when applicable. Once an Exchange has verified the relevant applicable enrollment information for an individual for a plan year, section 36B(c)(5) will not cause a month to fail to be a coverage month for the individual for the remainder of the plan year provided the Exchange follows the procedures in the CMS regulations for eligibility and verification relating to enrollee-reported changes in circumstances.

For example, assume all items in section 36B(c)(5)(B) have been verified for an individual and the individual is enrolled in a QHP and is determined to be eligible for APTC in the amount of \$250 per month beginning in January of a plan year. In June of the plan year, the individual informs the Exchange that the individual's projected household income will be less than previously projected and verified, which would make

the individual eligible for more than \$250 of APTC per month. If the Exchange maintains the current amount of \$250 of APTC per month and increases APTC only after it verifies the new lower household income amount, the section 36B(c)(5) verification requirements will be met for this individual. However, if the enrollee informs the Exchange that the enrollee's projected household income will be more than previously projected and verified, which would make the enrollee eligible for less than \$250 of APTC per month, section 36B(c)(5) does not prevent the Exchange from immediately implementing the lower APTC amount, prior to verification of the new information.

It is further anticipated that forthcoming CMS proposed regulations would provide one exception to this general rule that is consistent with section 36B(c)(5)(E). This one exception would be for situations in which the Secretary provides a verification waiver under section 36B(c)(5)(E). Under section 36B(c)(5)(E), the Secretary may waive the verification requirement in section 36B(c)(5)(A) in the case of an individual who is eligible to enroll in a QHP through an Exchange "during a SEP provided by the Exchange on the basis of a change in the family size of the individual." Primarily, a waiver in this context would permit the Exchange to pay APTC for the individual's QHP coverage before verification of the individual's eligibility for enrollment and APTC is completed.

The rules under 45 CFR 155.420 for SEPs do not explicitly identify which SEPs are based on a change in family size. The proposed regulations would identify the SEPs triggered by the events described in 45 CFR 155.420(d)(2)(i) and (ii) as SEPs based on change in family size referred to in section 36B(c)(5)(E). Generally, these triggering events are (1) when a qualified individual gains a dependent, which for purposes of the SEP rules, means any individual who is or may become eligible for coverage under the terms of a QHP because of a relationship to an enrollee, including an enrollee's spouse (rather than being limited to a dependent as defined under section 152); (2) when an

enrollee loses a dependent or dependent status through divorce; and (3) upon the death of an enrollee or a dependent of the enrollee. Thus, the proposed regulations would provide that the Secretary's authority to waive verification under section 36B(c)(5)(E) applies with respect to all individuals eligible to enroll in a QHP, including current enrollees, during a SEP that is triggered by an event described in 45 CFR 155.420(d)(2)(i) or (ii) by waiving, for coverage month purposes, the requirement to verify applicable enrollment information provided to an Exchange during the SEP.

c. Reconciliation of APTC for an individual's prior plan years

Section 36B(c)(6), as added by section 71303(a) of the OBBBA, provides that the term "coverage month" does not include, with respect to any individual covered by a QHP, any month for which the Exchange does not meet the requirements of 45 CFR 155.305(f)(4)(iii), as published in the ***Federal Register*** on June 25, 2025 (90 FR 27074), applied as though it applied to all plan years after 2025, with respect to the individual. Title 45 CFR 155.305(f)(4)(iii) relates to any individual determined to be ineligible for APTC for failing to reconcile APTC with the actual PTC allowed on the tax return for the year of coverage for the prior year of QHP coverage for which the Exchange would use tax data to verify household income and family size. The proposed regulations would provide that, for taxable years beginning after December 31, 2027, a month is not a coverage month for an individual for months APTC is paid if the Exchange through which the individual enrolled has failed to comply with section 36B(c)(6) for the month.

V. Eligible Alien Requirement and Conforming Amendments to PTC Computation

The proposed regulations would amend § 1.36B-3 to reflect the OBBBA's expansion of the limitation on aliens' eligibility for the PTC in section 36B(e)(1) to encompass individuals in a taxpayer's family who are aliens lawfully present in the U.S., but who are not eligible aliens, as defined in section 36B(e)(2)(B). The OBBBA section

71301 amendments to section 36B are effective for taxable years beginning after December 31, 2026. Specifically, the proposed regulations would amend § 1.36B-3 to provide that, in determining the premium assistance amount under § 1.36B-3(d)(1), a taxpayer must reduce both the enrollment premiums under § 1.36B-3(d)(1)(i) and the applicable benchmark plan premium under § 1.36B-3(d)(1)(ii) by the portion of the premiums attributable to any individual in the taxpayer's family enrolled in a QHP who is an alien not lawfully present in the U.S. or, if a lawfully present alien, is not an eligible alien. In addition, the proposed regulations would expand § 1.36B-3(l), which now applies to taxpayers with a family member who is an alien not lawfully present in the U.S., to also apply to taxpayers with a family member who is a lawfully present alien, but not an eligible alien.

The proposed regulations would also amend § 1.36B-3(h) relating to the manner in which, in computing the PTC, the enrollment premiums for a QHP are allocated among multiple families enrolled in the QHP. The proposed regulations would provide that if (1) a QHP covers more than one family on a single policy and (2) one or more of the families have individuals enrolled in the QHP who are aliens not lawfully present or, in the case of aliens who are lawfully present, are not eligible aliens, then taxpayers must allocate enrollment premiums in accordance with § 1.36B-3(h)(2). Because the actual enrollment premium is a single amount for the policy and is not family specific, an allocation is required to appropriately reflect the correct amount of enrollment premiums for each family when computing the PTC. Consequently, this allocation must exclude individuals enrolled in the QHP who are aliens not lawfully present or, in the case of aliens who are lawfully present, are not eligible aliens.

The proposed rule would provide that a taxpayer's allocation of the monthly enrollment premium equals the total monthly enrollment premium for the policy (including the premium attributable to any individuals not lawfully present or if lawfully

present, not eligible aliens), multiplied by the ratio of the monthly applicable benchmark plan premium for the taxpayer's family, which is determined by excluding any alien who is not lawfully present, or a lawfully present alien but not an eligible alien, to the monthly applicable benchmark plan premium for all families enrolled in the policy, which is determined by including any alien who is not lawfully present or, if an alien lawfully present, is not an eligible alien. Using the applicable benchmark plan premium for all families enrolled in the policy, including any individuals who are not lawfully present or, if lawfully present aliens, are not eligible aliens, as the denominator ensures that the full monthly enrollment premium is consistently allocated across all families who share the same policy.

VI. Elimination of Excess APTC Repayment Limitation

The proposed regulations would revise § 1.36B-4(a)(3) to reflect the OBBBA amendment to section 36B(f)(2)(B), which eliminates the limitation on the amount of excess APTC that a taxpayer is required to repay for taxable years beginning after December 31, 2025. Consequently, when reconciling APTC on a taxpayer's Federal income tax return for such taxable year, the full amount by which APTC exceeds PTC allowed under section 36B increases the taxpayer's tax liability for that taxable year.

VII. Information reporting by Exchanges

Section 1.36B-5 provides the QHP enrollment information that Exchanges must report to taxpayers, on Form 1095-A, *Health Insurance Marketplace Statement*, and to the IRS. Taxpayers use this information to compute their PTC and to reconcile the APTC paid for their coverage and the coverage of other family members with the PTC the taxpayer is allowed.

To conform to the changes to section 36B(e) made by section 71301 of the OBBBA relating to the computation of the PTC for the QHP coverage of individuals who are lawfully present aliens but not eligible aliens, the proposed regulations would amend

§ 1.36B-5. Specifically, the proposed regulations would provide that in the case of taxpayers for whom APTC was paid, Exchanges must exclude from the amount of the reported enrollment premiums and the benchmark plan premiums reported on Form 1095-A and to the IRS, the portion of the premiums allocable to individuals in the tax filer's family who are aliens not lawfully present or who are lawfully present aliens but not eligible aliens.

Proposed Applicability Dates

Proposed §§ 1.36B-1(o) and 1.36B-3(n), would provide that proposed §§ 1.36B-1(c)(2) and 1.36B-3(c)(6) and (7), respectively, apply to taxable years beginning after December 31, 2027. Proposed § 1.36B-1(o) would provide that proposed § 1.36B-1(c)(3) applies to plan years beginning on or after **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. Proposed § 1.36B-2(e) would remove § 1.36B-2(b)(5) for taxable years beginning on or after **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. Proposed § 1.36B-2(e) would provide that proposed § 1.36B-2(b)(5)(i) and (b)(6) apply to taxable years beginning on or after **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. See section 7805(b)(1)(B). Proposed § 1.36B-4(c)(3) would provide that § 1.36B-4(a)(3) will not apply to taxable years beginning on or after **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. Proposed §§ 1.36B-2(e), 1.36B-3(n), and 1.36B-5(h) would provide that proposed § 1.36B-2(c)(2)(ii), (v), (vi), and (c)(2)(vii)(G) through (I); proposed § 1.36B-3(d)(2), (h), (l)(1), and (l)(2)(i); and proposed § 1.36B-5(c)(1)(iv) and (viii), and (c)(3)(iii), respectively, apply to taxable years beginning after December 31, 2026. See section 7805(b)(1)(B). While certain sections of the proposed regulations apply to tax years and plan years beginning on or after **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, the related statutory provisions are effective for tax years and plan years beginning on or after December 31, 2025, and supersede any conflicting provisions in

the existing regulations as of that date.

Special Analyses

I. Regulatory Planning and Review – Economic Analysis

Executive Orders 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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility.

The proposed regulations have been designated by the Office of Management and Budget's (OMB's) Office of Information and Regulatory Affairs (OIRA) as subject to review under Executive Order 12866 pursuant to the Memorandum of Agreement (MOA, July 4, 2025) between the Treasury Department and the OMB regarding review of tax regulations. OIRA has determined that the proposed rulemaking is significant under section 3(f) of Executive Order 12866 and subject to review under Executive Order 12866 and section 1(b) of the MOA. Accordingly, the proposed regulations have been reviewed by OMB.

a. Need for Regulation

The OBBBA revised the eligibility and computational rules for an individual taxpayer's PTC, and these proposed regulations are necessary to comply with the OBBBA amendments to section 36B.

b. The Statute and the Proposed Regulations

The OBBBA amended section 36B of the Code. Additionally, the OBBBA amendment to section 1902 of the Social Security Act affects the section 36B "coverage month" determination.

Section 71301(a) expands the existing section 36B(e)(1) rule that excludes family members who are not lawfully present from PTC computations. The amendment,

effective for taxable years beginning after December 31, 2026, also excludes lawfully present alien family members who are not “eligible aliens.” The proposed regulations would require taxpayers to reduce the enrollment premiums and premiums for the applicable benchmark plan allocable to family members who are not lawfully present or who are aliens lawfully present but not eligible aliens, apply that reduction after any multiple family allocation of enrollment premiums, and exclude those individuals from certain household income calculations used for applicable percentage purposes.

Section 71302(a) removes the rule in section 36B(c)(1)(B) that previously treated certain taxpayers with household income below 100 percent of the applicable FPL as applicable taxpayers if they, or a family member, were lawfully present aliens not eligible for Medicaid because of immigration status, effective for taxable years beginning after December 31, 2025. The proposed regulations would remove the corresponding regulatory provision.

Section 71119 added section 1902(xx)(7)(B) to the Social Security Act and provides, for section 36B coverage month purposes, that an individual is deemed eligible for Medicaid minimum essential coverage for a month if the individual would have been eligible for Medicaid but for a failure to meet a community engagement requirement under section 1902(xx)(1). The proposed regulations would provide that this deemed Medicaid eligibility starts when Medicaid would otherwise have begun, blocks use of the Exchange Medicaid ineligibility safe harbor in these cases, ends once Medicaid ineligibility arises for another reason, and preserves an anti-abuse rule for intentional or reckless misstatements.

Section 71303(a) adds section 36B(c)(5), effective for taxable years beginning after December 31, 2027. Section 36B(c)(5) makes Exchange verification a condition of having a coverage month and, under the related amendment to section 36B(c)(3)(A), of having a QHP for section 36B purposes. The proposed regulations would provide that a

month is not a coverage month for an individual who enrolls in a QHP unless the Exchange verifies the individual's residence and citizenship, national status, or lawful presence for the month. For individuals for whom APTC is paid, the proposed regulations would also provide that a month is not a coverage month for an individual unless the Exchange verifies the individual's household income, family size, absence of other minimum essential coverage, and eligible alien status where relevant. The proposed regulations would further coordinate these tax rules with Exchange procedures for re-enrollment and changes in circumstances by tying tax consequences to whether Exchange verification requirements have been satisfied.

Section 71303(a) also adds section 36B(c)(6), which provides that a month is not a coverage month for an individual covered by a QHP if the Exchange fails to satisfy the applicable prior reconciliation requirements with respect to that individual.² That prior reconciliation requirement generally requires the Exchange to check whether advance credit payments were made for the tax filer, or the tax filer's spouse if the tax filer is married, and whether or not the tax filer or spouse failed to file the required Federal income tax return and reconcile those advance credit payments for the relevant prior year used in the Exchange's verification process. Thus, the proposed regulations would provide that, for individuals for whom advance credit payments are made, a month is not a coverage month when the Exchange fails to carry out the procedures needed to verify whether prior reconciliation requirements were satisfied.

Section 71304(a) amends section 36B(c)(3)(A) to provide that, for plan years beginning after December 31, 2025, the term "qualified health plan" does not include certain plans enrolled in through income-based SEPs. The proposed regulations would

² Section 36B(c)(6) cites to the reconciliation requirements of 45 CFR 155.305(f)(4)(iii), as published in the **Federal Register** on June 25, 2025.

clarify that this exclusion applies when no qualifying event or specified change in circumstances exists.

Section 36B(c)(5)(E), added by section 71303(a), authorizes the Secretary to waive the section 36B(c)(5)(A) verification requirement for an individual who enrolls in a QHP through an Exchange during a SEP based on a change in family size. The proposed regulations would identify change in family size SEPs based on the events described in 45 CFR 155.420(d)(2)(i) and (ii), which generally include gaining a dependent, losing a dependent or dependent status through divorce or legal separation, and the death of an enrollee or dependent. The proposed regulations would provide that the waiver applies for all individuals eligible to enroll in a QHP, including current enrollees, during a SEP triggered by one of those events, by waiving, for coverage month purposes, the requirement to verify applicable enrollment information provided to an Exchange during the SEP.

Section 71305 removes section 36B(f)(2)(B), effective for taxable years beginning after December 31, 2025. Section 36B(f)(2)(B) previously limited the amount by which taxpayers below 400 percent of the FPL had to increase tax liability when advance credit payments exceeded the PTC properly allowed. The proposed regulations would make conforming changes by amending § 1.36B-4(a)(3)(i) to provide that the repayment limitation does not apply for taxable years beginning after December 31, 2025. The proposed regulations would make conforming changes by amending § 1.36B-4(a)(3)(iii) to provide that the tax liability increase that must be used by taxpayers claiming a section 162(l) deduction for their QHP premiums applies only for taxable years beginning before January 1, 2026.

Section 36B(f)(3) and the existing regulations require Exchanges to report monthly enrollment premiums, applicable benchmark-plan premiums, and advance credit payments on Form 1095-A and to the IRS. The proposed regulations would

amend § 1.36B-5 to provide that, for taxpayers for whom advance credit payments were made, Exchanges must exclude from the enrollment premium and premium for the applicable benchmark plan amounts reported on Form 1095-A and to the IRS the portion allocable to family members who are not lawfully present or are aliens lawfully present but not eligible aliens. The proposed regulations would also conform the mid-month enrollment reporting rules to ensure that, when the revised reporting rule applies, amounts attributable to such individuals are excluded from the relevant enrollment premium and applicable benchmark plan premium reporting. These reporting changes apply for taxable years beginning after December 31, 2026.

c. Baseline

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

d. Affected Entities and Taxpayers

The proposed regulations are expected to affect about 15.6 million total individuals enrolled in Exchange coverage, including 13.5 million enrollees potentially eligible to claim PTC.

The proposed regulations may also affect the 22 State-Based Exchanges that administer eligibility, verification, and reporting processes for those enrollees. The costs and benefits associated with Exchange administration of those processes are expected to be addressed in forthcoming regulations issued by the Department of Health and Human Services.

e. Economic Effects of the Proposed Regulations

The proposed regulations would clarify the amended statute and the preexisting regulations by clarifying when Exchange enrollment produces section 36B consequences and how premium amounts must be computed and reported. The

proposed regulations provide rules describing how eligibility, reporting, and coverage-month consequences would be operationalized. In the absence of regulatory clarification, similarly situated taxpayers could face inconsistent Exchange treatment, less reliable reporting information, and greater uncertainty regarding whether months of enrollment are coverage months and how the PTC must be computed when completing their Federal income tax returns. The proposed regulations provide clarity and should result in fewer amended tax returns. This should allow Exchanges and issuers to implement the amended statute with greater predictability and allow taxpayers to determine their correct Federal income tax liability with greater certainty.

i. Eligible-alien reporting approach reduces reporting and implementation burdens

The proposed regulations would also reduce reporting and implementation burdens in the eligible-alien context by selecting a narrower reporting approach for Form 1095-A. The proposed rule would require Exchanges, for taxpayers for whom APTC was paid, to exclude from reported enrollment premiums and premiums for the applicable benchmark plan the portions allocable to individuals who are lawfully present but not eligible aliens. An alternative to the proposed regulations would extend that reporting rule to unsubsidized enrollees. That alternative would require reporting adjustments for approximately 2.1 million unsubsidized Exchange enrollees, representing 13 percent of total Exchange enrollees in 2028, even though Exchanges generally would not otherwise need to determine eligible-alien status for those enrollees for purposes of administering APTC. This alternative was not chosen because Treasury and the IRS expected that it would require Exchanges to incur significant administrative costs. The costs and benefits associated with Exchange administration of the eligibility, verification, and reporting processes are expected to be addressed in parallel regulations issued by the Department of Health and Human Services. See Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for

2027; and Basic Health Program, 91 FR 29526 (May 20, 2026) (addressing Exchange eligibility and verification requirements and administration of advance payments of the premium tax credit). Under current regulations, Exchanges do not verify eligible-alien status for non-financial-assistance applicants. Treasury and the IRS estimate that the proposed regulations, relative to the alternative, would reduce the cost and disruption of system changes, and avoid a broader redesign of Exchange reporting and related data submissions. For affected APTC households, the proposed narrower approach would also improve the alignment between Form 1095-A reporting and the amounts relevant to section 36B reconciliation, which should reduce misreporting on Form 8962, *Premium Tax Credit (PTC)*. For example, assume a household consists of one U.S. citizen and one lawfully present individual who is not an eligible alien, and that each individual has a monthly premium of \$500. Reporting the \$1,000 premium on Form 1095-A would not reflect the premium amount that the household should use in computing their allowable PTC. Conversely, leaving the amount blank would require the taxpayer to manually determine the correct amount to use, potentially by contacting the issuer. The proposed regulations would instead require a premium of \$500 to be reported on Form 1095-A, thus enabling the taxpayer to complete Form 8962 using the amount reported on Form 1095-A. This should reduce taxpayer burden and the risk that taxpayers will miscalculate or misreport the premium amount they use to determine the PTC.

ii. Verification and family-size SEP waiver

The proposed regulations would also produce important economic effects through the verification provisions. The OBBBA gave the Secretary authority, in consultation with HHS, to specify additional criteria necessary for verification. The proposed regulations would exercise that authority by requiring Exchanges to verify, for enrollment eligibility, an individual's place of residence and that the individual is a U.S. citizen, a national of the U.S., or an alien lawfully present in the United States. The

proposed regulations would also clarify that, for months for which APTC is paid, Exchanges must verify both enrollment-eligibility items and the items relevant to APTC eligibility. An alternative would have been to omit the additional criteria necessary for verification. Relative to the alternative, the proposed regulations would strengthen program integrity because they align coverage-month treatment with the prerequisites for Exchange enrollment and APTC. For example, assume two individuals enroll in full-price Exchange coverage without APTC. The Exchange verifies the first individual's eligibility to enroll, including residence and citizenship, national, or lawful-presence status, but is unable to verify the second individual's eligibility to enroll and removes the second individual from coverage after the applicable verification process. The proposed regulations would clarify that section 36B(c)(5) does not prevent the first individual's months of enrollment from being coverage months solely because no APTC was paid, while the second individual's months of unverified enrollment would not be coverage months for purposes of the PTC. Relative to the alternative, the proposed regulations would also reduce the risk that credits are paid for months that should not be subsidized. As proposed, the regulations would also reduce burdens on States and Exchanges by giving them an administrable set of criteria to implement rather than leaving the consequences of section 36B(c)(5) to case-by-case interpretation. The administrative costs, operational effects, and benefits associated with Exchange eligibility, verification, and reporting procedures are expected to be evaluated in parallel regulations issued by the Department of Health and Human Services.

The proposed regulations would also make a separate policy choice under section 36B(c)(5)(E) to apply the family-size SEP waiver broadly to any SEP triggered by a change in family size. As proposed, that waiver would extend to the SEP categories identified by cross-reference to the CMS rules, including newborn, adoption, or foster-care events, marriage, and loss of dependent through death, divorce, or legal

separation. An alternative to the proposed broad waivers would be a partial waiver that did not include all the categories listed in the CMS rules. Such an alternative would be operationally complex and could create gaps or delays in access to subsidized coverage for vulnerable populations. HHS, in consultation with the Treasury Department, identified a risk that, while verification remained pending for an individual in the household, the SEP window could expire or that families could face full-price premiums while. Relative to the alternative, the broader waiver should reduce the risk of delayed or disrupted coverage in family-change situations and should reduce the out-of-pocket health care costs and administrative strain that would arise if affected households were required to complete full verification before any APTC could be applied. The Treasury Department and the IRS estimate that roughly 50,000 families with newborns will benefit.

To assess the impact of the family-size SEP waiver, the Treasury Department and the IRS analyzed data on Exchange enrollment and APTC extracted from information returns, specifically Form 1095-A. Based on that analysis, approximately 0.3 percent of Exchange plans with APTC include a newborn during the plan year. The average monthly APTC associated with newborn coverage is estimated to be approximately \$222. The estimated number of newborns in APTC households, 50,000 newborns, is then multiplied by the average monthly APTC attributable to newborn coverage and by the expected duration of verification-related delay absent the waiver, 2 months, resulting in approximately \$22 million in APTC that could be delayed for affected households under an alternative rule that did not waive verification for newborn-related family-size SEPs.

iii. Medicaid community engagement

The proposed regulations would also clarify how the new Medicaid community engagement requirement operates for section 36B purposes. In general, an individual

who is eligible for or enrolled in Medicaid is treated as having minimum essential coverage and therefore is not eligible for the PTC for that month. As of February of 2026, CMS reported that approximately 68 million individuals were enrolled in Medicaid, making the interaction of PTC and Medicaid eligibility rules relevant to a substantial population. The statute deems an individual to be eligible for minimum essential coverage if the individual would have been eligible for Medicaid but for failure to meet community engagement requirements, but it did not fully specify how that deemed-minimum essential coverage rule should operate when the individual later becomes ineligible for Medicaid for a different reason. The proposed regulations would resolve that question by providing that once an individual is no longer ineligible for Medicaid solely because of failure to meet the requirement to demonstrate community engagement, the deemed-minimum essential coverage treatment no longer applies. They would also provide that if, after enrollment in a QHP, the Exchange later determines or assesses the individual to be ineligible for Medicaid for a reason other than failure to meet the requirement to demonstrate community engagement, the ordinary rule treating the individual as not eligible for Medicaid can apply from that later month.

This approach provides an administrable and well-targeted balance by tying the application of the community engagement requirement to the reason for Medicaid ineligibility in the relevant month. The proposed rule would preserve program integrity by preventing taxpayers who remain subject to the Medicaid community engagement requirement from avoiding that requirement through qualified health plan enrollment. At the same time, it would allow taxpayers whose circumstances change so that community engagement is no longer the sole reason for Medicaid ineligibility to be treated under the ordinary section 36B rules for later months. The result should be

greater certainty at enrollment and tax filing and fewer disputes about whether an earlier Medicaid determination continues to control after a later change in circumstances.

iv. Elimination of excess APTC repayment limitations

The elimination of the excess APTC repayment limitation is expected to increase the amount of excess APTC that affected taxpayers must repay when filing their Federal income tax returns. The Treasury Department and the IRS estimate that, in 2028, approximately 3.7 million returns will include a repayment of excess APTC.

II. Paperwork Reduction Act

These proposed regulations do not impose any additional information collection requirements in the form of reporting, recordkeeping requirements, or third-party disclosure statements. Taxpayers who claim PTC on their income tax returns are required to file Form 8962. The proposed regulations, if finalized, would require the IRS to revise the instructions for Form 8962. For purposes of the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(c)), the reporting burden associated with the collection of information for Form 8962 will be reflected in the PRA submission associated with income tax returns under the OMB control number 1545-0074. To the extent there is a change in burden because of these proposed regulations, the change in burden will be reflected in the updated burden estimates for Form 8962. Nothing in these proposed 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.

In addition, these proposed regulations, if finalized, would amend § 1.36B-5, which requires Exchanges to report information to the IRS and to taxpayers. This information enables taxpayers to claim a PTC on their tax return and to comply with the requirement in § 1.36B-4 to reconcile the APTC paid on their behalf with the PTC they

may claim. Exchanges use Form 1095-A to report the information provided in § 1.36B-5 to taxpayers. The proposed regulations, if finalized, will require the IRS to revise the instructions for recipients of Form 1095-A and the instructions for Exchanges completing Form 1095-A. For purposes of the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(c)), the reporting burden associated with the collection of information for Form 1095-A will be reflected in the PRA submission associated with Form 1095-A under the OMB control number 1545-2232. To the extent there is a change in burden because of these final regulations, the change in burden will be reflected in the updated burden estimates for Form 1095-A.

III. Regulatory Flexibility Act

When an agency issues a proposed rulemaking, the Regulatory Flexibility Act (5 U.S.C. chapter 6) (RFA) requires the agency to “prepare and make available for public comment an initial regulatory flexibility analysis” that “describe[s] the impact of the proposed rule on small entities.” See 5 U.S.C. 603(a). The term “small entities” is defined in 5 U.S.C. 601 to mean “small business,” “small organization,” and “small governmental jurisdiction,” which are also defined in 5 U.S.C. 601. Small business size standards define whether a business is “small” and have been established for types of economic activities, or industry, generally under the North American Industry Classification System (NAICS). See title 13, part 121 of the Code of Federal Regulations (Small Business Size Regulations). The size standards look at various factors, including annual receipts, number of employees, and amount of assets, to determine whether the business is small. See title 13, § 121.201 of the Code of Federal Regulations for the Small Business Size Standards by NAICS Industry.

Section 605 of the RFA provides an exception to the requirement to prepare an initial regulatory flexibility analysis if the agency certifies that the proposed rulemaking will not have a significant economic impact on a substantial number of small entities.

The Treasury Department and the IRS hereby certify that these proposed 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 proposed regulations falls on individual taxpayers, and entities will experience only small changes.

IV. Section 7805(f)

Pursuant to section 7805(f) of the Code, these 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.

V. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 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 proposed regulation 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.

VI. 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 Executive order. This proposed regulation 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 Executive order.

Comments and Public Hearing

Before these proposed regulations are adopted as final regulations,

consideration will be given to comments that are submitted timely to the IRS as prescribed in this preamble in the **ADDRESSES** section. The Treasury Department and the IRS request comments on all aspects of the proposed regulations, including the economic impact of the proposed regulations. Any comments submitted will be made available at www.regulations.gov or upon request. Once submitted to the Federal eRulemaking Portal, comments cannot be edited or withdrawn.

A telephonic public hearing is being held on December 8, 2026, beginning at 10 a.m. ET. The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit an outline of the topics to be discussed as well as the time to be devoted to each topic by **[INSERT DATE 45 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. A period of ten minutes will be allocated to each person for making comments. After the deadline for receiving outlines has passed, the IRS will prepare an agenda containing the schedule of speakers. Copies of the agenda will be made available free of charge. If no outlines of the topics to be discussed at the hearing are received by **[INSERT DATE 45 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, the public hearing will be cancelled. If the public hearing is cancelled, a notice of cancellation of the public hearing will be published in the *Federal Register*.

Individuals who want to testify by telephone at the public hearing must send an email to publichearings@irs.gov to receive the telephone number and access code for the hearing. The subject line of the email must contain the regulation number REG-101576-26 and the language TESTIFY Telephonically. For example, the subject line may say: Request to TESTIFY Telephonically at Hearing for REG-101576-26.

Individuals who want to attend the public hearing telephonically without testifying must also send an email to publichearings@irs.gov to receive the telephone number and access code for the hearing. The subject line of the email must contain the

regulation number REG-101576-26 and the language ATTEND Hearing Telephonically. For example, the subject line may say: Request to ATTEND Hearing Telephonically for REG-101576-26. Requests to attend the public hearing must be received by 5:00 p.m. ET on December 4, 2026.

Hearings will be made accessible to people with disabilities. To request special assistance during the hearing, contact the Publications and Regulations Section of the Office of Associate Chief Counsel (Procedure and Administration) by sending an email to *publichearings@irs.gov* (preferred) or by telephone at (202) 317-6901 (not a toll-free number) by December 3, 2026.

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 proposed regulations is Mia C. Romano 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 the regulations.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

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

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by adding entries in numerical order for § 1.36B-3(c)(6)(i) and 1.36B-3(c)(6)(iii) to read in part as follows:

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

* * * * *

Section 1.36B-3(c)(6)(i) also issued under 26 U.S.C. 36B(c)(5)(B)(v).

Section 1.36B-3(c)(6)(iii) also issued under 26 U.S.C. 36B(c)(5)(E).

* * * * *

Par. 2. Section 1.36B-1 is amended by revising paragraphs (c) and (o)(1), and adding paragraph (o)(4) to read as follows:

§ 1.36B-1 Premium tax credit definitions.

* * * * *

(c) *Qualified health plan*—(1) *In general.* Except as provided in paragraphs (c)(2) and (3) of this section, the term “qualified health plan” has the same meaning as in section 1301(a) of the Affordable Care Act (42 U.S.C. 18021(a)) but does not include a catastrophic plan described in section 1302(e) of the Affordable Care Act (42 U.S.C. 18022(e)).

(2) *Pre-enrollment verification process required.* The term “qualified health plan” does not include any plan enrolled in through an Exchange that fails to provide a pre-enrollment verification process through which an applicant may, beginning not later than August 1, verify with the Exchange the applicant's household income and eligibility for enrollment in a plan for the plan year beginning in the subsequent year.

(3) *Certain special enrollment periods.* The term “qualified health plan” does not include any plan enrolled in during a special enrollment period provided for by an Exchange--

(i) On the basis of the percentage that the individual's expected household income bears to the Federal poverty line for the individual's family size as is prescribed by the Secretary of Health and Human Services for purposes of the enrollment period; and

(ii) Not in connection with the occurrence of an event or change in circumstances specified by the Secretary of Health and Human Services for such purposes.

* * * * *

(o) * * *

(1) Except as provided in paragraphs (o)(2) through (4) of this section, this section applies to taxable years ending after December 31, 2013.

* * * * *

(4) Paragraph (c)(2) of this section applies to taxable years beginning after December 31, 2027. Paragraph (c)(3) of this section applies to plan years beginning on or after **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

Par. 3. Section 1.36B-2 is amended by:

1. Removing paragraph (b)(5) and redesignating paragraphs (b)(6) and (7) as new paragraphs (b)(5) and (6), respectively;

2. Revising the introductory text of newly redesignated paragraph (b)(5)(i);

3. Revising newly redesignated paragraph (b)(5)(ii);

4. Removing newly redesignated paragraphs (b)(5)(iii) and (iv);

5. In newly redesignated paragraph (b)(6), removing the language “or (b)(6)”;

6. Revising paragraphs (c)(2)(ii) and (v);

7. Redesignating paragraph (c)(2)(vi) as paragraph (c)(2)(vii) and adding new paragraph (c)(2)(vi);

8. In newly redesignated paragraph (c)(2)(vii), designating *Example 1* through *Example 6* as paragraphs (c)(2)(vii)(A) through (F), respectively;

9. In newly designated paragraph (c)(2)(vii)(C), removing the language “*Example 2*” and adding the language “paragraph (c)(2)(vii)(B) of this section (*Example 2*)” in its place;

10. In newly designated paragraph (c)(2)(vii)(F), removing the language

“*Example 5*” and adding the language “paragraph (c)(2)(vii)(E) of this section (*Example 5*)” in its place;

11. Adding paragraphs (c)(2)(vii)(G), (H), and (I); and

12. Revising paragraphs (e)(1), (2), and (6) and adding paragraph (e)(7).

The revisions and additions read as follows:

§ 1.36B-2 Eligibility for premium tax credit.

* * * * *

(b) * * *

(5) * * *

(i) * * * A taxpayer whose household income for a taxable year is less than 100 percent of the Federal poverty line for the taxpayer's family size is treated as an applicable taxpayer for the taxable year if—

* * * * *

(ii) *Exceptions.* This paragraph (b)(5) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange for the year of coverage. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows the information provided to the Exchange is inaccurate.

* * * * *

(c) * * *

(2) * * *

(ii) *Obligation to complete certain requirements to obtain coverage--(A)*

Administrative requirements. An individual who meets the criteria for eligibility for

government-sponsored minimum essential coverage must complete certain administrative requirements in order to receive benefits. Except as provided in paragraph (c)(2)(ii)(B) of this section, an individual who fails by the last day of the third full calendar month following the event that establishes eligibility under paragraph (c)(2)(i) of this section to complete the requirements to obtain government-sponsored minimum essential coverage (other than a veteran's health care program) is treated as eligible for government-sponsored minimum essential coverage as of the first day of the fourth calendar month following the event that establishes eligibility.

(B) *Medicaid community engagement requirement.* For taxable years beginning after December 31, 2026, an individual who is determined or assessed (within the meaning of 45 CFR 155.302(b)) by an Exchange to be not eligible for Medicaid solely because the individual failed to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1) is treated as eligible for minimum essential coverage under section 5000A(f)(1)(A)(ii) as of the later of the first day of the first full month the individual would have been eligible to receive benefits under the Medicaid program or the first day of the first calendar month beginning after the assessment or determination that the individual would have been eligible for Medicaid but for the failure to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1).

(C) *No longer ineligible for failing to demonstrate community engagement.* For any month in which an individual described in paragraph (c)(2)(ii)(B) of this section is determined or assessed by an Exchange to be, or becomes, no longer ineligible for Medicaid solely for failing to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1), paragraph (c)(2)(ii)(B) of this section does not apply.

* * * * *

(v) Determination of Medicaid or Children's Health Insurance Program (CHIP)

ineligibility—(A) In general. Except as provided in paragraph (c)(2)(v)(B) of this section, an individual is treated as not eligible for Medicaid, CHIP, or a similar program such as a Basic Health Program, for a period of coverage under a qualified health plan if, when the individual enrolls in the qualified health plan, an Exchange conducts an eligibility determination or, if applicable, eligibility assessment (within the meaning of 45 CFR 155.302(b)) for Medicaid, CHIP, or a similar program and determines or assesses the individual to be not eligible for coverage under the program.

(B) Determination of Medicaid community engagement. For taxable years beginning after December 31, 2026, paragraph (c)(2)(v)(A) of this section does not apply for an individual who is determined or assessed by an Exchange to be not eligible for Medicaid solely because the individual failed to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1).

(C) Determination of Medicaid ineligibility after enrollment. If an individual treated as eligible for Medicaid due to an Exchange determination or assessment that the individual was ineligible for Medicaid as described in paragraph (c)(2)(ii)(B) of this section enrolls in a qualified health plan and, after the enrollment, an Exchange conducts an eligibility determination or, if applicable, eligibility assessment (within the meaning of 45 CFR 155.302(b)) for Medicaid and determines or assesses the individual to be not eligible for Medicaid for a reason other than the individual failing to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1), then the individual is treated as not eligible for Medicaid for the period of coverage under the qualified health plan as of the first day of the first calendar month after the Exchange makes such determination or assessment.

(vi) Inapplicability due to intentional or reckless disregard of the facts.

Paragraphs (c)(2)(ii)(C), (c)(2)(v)(A), and (c)(2)(v)(C) of this section do not apply for an

individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange for the year of coverage. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that information provided to the Exchange is inaccurate.

(vii) * * *

(G) *Example 7: Medicaid ineligibility determination - community engagement.*

Taxpayer H is determined to be ineligible for Medicaid as of January 1, 2027, solely because of H's failure to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1). H begins a new job in March of 2027 that makes H ineligible for Medicaid due to H's income being above the income threshold for Medicaid eligibility in H's state. In March, H goes to the Exchange in H's rating area and enrolls in a qualified health plan and is determined to be eligible for advance credit payments beginning in April 2027. H was not enrolled in a qualified health plan before April 2027. Under paragraph (c)(2)(v)(A) of this section, H is treated as ineligible for Medicaid for the period of H's qualified health plan coverage in 2027 because, when H enrolled in a qualified health plan, the Exchange determined that H was ineligible for Medicaid for a reason other than failing to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1).

(H) *Example 8—(1) Mid-year Medicaid ineligibility redetermination - community engagement.* The facts are the same as in paragraph (c)(2)(vii)(G) of this section (*Example 7*), except that H enrolled in a qualified health plan as of January 1, 2027, and paid the total amount of the premiums for the coverage for January through March. Thus, January and February are not coverage months for H because H's ineligibility for

Medicaid for those months is solely due to H's failure to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1).

(2) No longer ineligible for failing to demonstrate community engagement.

Because H's income for March is above the income threshold for Medicaid eligibility in H's state, March is the month H becomes no longer ineligible for Medicaid solely for failing to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1), as described in paragraph (c)(2)(ii)(C) of this section. For March, H does not meet the criteria for eligibility for Medicaid as described in paragraph (c)(2)(i) of this section and March may be a coverage month for H.

(3) Determination of Medicaid ineligibility after enrollment. Under paragraph (c)(2)(v)(C) of this section, H is treated as ineligible for Medicaid in April and the months of H's 2027 enrollment after April. This is because after H's January enrollment in a qualified health plan, the Exchange conducted an eligibility determination for Medicaid in March and determined H to be ineligible for Medicaid for a reason other than failing to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1). Thus, April, the first calendar month after the Exchange made such determination, and the months after April in which H was enrolled in a qualified health plan, may be coverage months for H.

(l) Example 9—(1) Mid-year Medicaid eligibility redetermination – community engagement. Taxpayer J is determined by an Exchange to be ineligible for Medicaid as of January 1, 2027, solely because of J's failure to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1). J enrolls in a qualified health plan through the Exchange as of January 1, 2027, and is determined to be ineligible for advance credit payments consistent with paragraph (c)(2)(ii)(B) of this section. Subsequently, J meets the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1) and meets the criteria for eligibility for Medicaid as described in

paragraph (c)(2)(i) of this section as of April 1, 2027.

(2) No longer ineligible for failing to demonstrate community engagement.

Because J becomes eligible for Medicaid as of April 1, 2027, J is no longer ineligible for Medicaid solely for failing to meet the requirement to demonstrate community engagement under 42 U.S.C. 1396a(xx)(1), as described in paragraph (c)(2)(ii)(C) of this section. Thus, paragraph (c)(2)(ii)(B) of this section does not apply to J starting with the month of April 2027.

(3) Administrative requirements. Under paragraph (c)(2)(ii)(A) of this section, J must complete certain administrative requirements necessary to receive Medicaid benefits because J meets the criteria for eligibility for Medicaid as described in paragraph (c)(2)(i) of this section. If J does not complete the administrative requirements necessary to enroll in Medicaid by June 30, 2027, which is the last day of the third full calendar month following the event that establishes J's eligibility (J meeting the requirement to demonstrate community engagement and, thus, the criteria for eligibility for Medicaid), J is treated as eligible for government-sponsored minimum essential coverage under paragraph (c)(2)(ii)(A) of this section as of July 1, 2027, the first day of the fourth calendar month following the event that establishes J's eligibility.

* * * * *

*(e) * * **

(1) Except as provided in paragraphs (e)(2) through (7) of this section, this section applies to taxable years ending after December 31, 2013.

(2) Paragraph (c)(2)(vi) of this section applies to taxable years beginning after December 31, 2026. The last three sentences of § 1.36B-2(c)(2)(v) as contained in 26 CFR part 1 edition revised as of April 1, 2025, apply to taxable years beginning after December 31, 2016, and ending before January 1, 2027. Paragraph (b)(5)(i) of this section applies to taxable years beginning on or after **[INSERT DATE OF**

PUBLICATION IN THE FEDERAL REGISTER]. Section 1.36B-2(b)(6)(i) as contained in 26 CFR part 1 edition revised as of April 1, 2025, applies to taxable years ending after December 31, 2013, and beginning before **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. Paragraphs (b)(5)(ii), (c)(3)(i), and (c)(3)(iii)(A), the last three sentences of paragraph (c)(3)(v)(A)(3), and paragraph (c)(4) of this section apply to taxable years beginning after December 31, 2016. Section 1.36B-2(b)(6), (c)(3)(i), (c)(3)(iii)(A), and (c)(4) as contained in 26 CFR part 1 edition revised as of April 1, 2016, apply to taxable years ending after December 31, 2013, and beginning before January 1, 2017.

* * * * *

(6) Paragraph (c)(2)(v) of this section applies to taxable years beginning after December 31, 2026. The first sentence of § 1.36B-2(c)(2)(v) as contained in 26 CFR part 1 edition revised as of April 1, 2025, applies to taxable years beginning on or after January 1, 2025, and ending before January 1, 2027. The first sentence of § 1.36B-2(c)(2)(v) as contained in 26 CFR part 1 edition revised as of April 1, 2024, applies to taxable years ending after December 31, 2013, and beginning before January 1, 2025.

(7) Paragraphs (c)(2)(ii) and (c)(2)(vii)(G) through (I) of this section apply to taxable years beginning after December 31, 2026. Paragraph (c)(2)(ii) of this section as contained in 26 CFR part 1 edition revised as of April 1, 2025, applies to taxable years beginning before December 31, 2026. Paragraph (b)(6) of this section applies to taxable years beginning on or after **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. Section 1.36B-2(b)(5) and (7) as contained in 26 CFR part 1 edition revised as of April 1, 2025, applies to taxable years ending after December 31, 2013, and beginning before **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

Par. 4. Section 1.36B-3 is amended by:

1. Revising paragraph (c)(1);
2. Redesignating paragraph (c)(6) as paragraph (c)(8) and adding new paragraph (c)(6);
3. Adding paragraph (c)(7);
4. In newly redesignated paragraph (c)(8), designating *Example 1* through *Example 4* as paragraphs (c)(8)(i) through (iv), respectively.
5. In newly designated paragraph (c)(8)(i), redesignating paragraphs (c)(8)(i)(i) and (ii) as paragraphs (c)(8)(i)(A) and (B), respectively.
6. In newly designated paragraph (c)(8)(ii), redesignating paragraphs (c)(8)(ii)(i) and (ii) as paragraphs (c)(8)(ii)(A) and (B), respectively.
7. In newly designated paragraph (c)(8)(iii), redesignating paragraphs (c)(8)(iii)(i) and (ii) as paragraphs (c)(8)(iii)(A) and (B), respectively.
8. Redesignating paragraph (d)(2) as paragraph (d)(3), and adding new paragraph (d)(2);
9. In newly redesignated paragraph (d)(3), designating *Example 1* through *Example 3* as paragraphs (d)(3)(i) through (iii), respectively.
10. In newly designated paragraph (d)(3)(ii), redesignating paragraphs (d)(3)(ii)(i) through (d)(3)(ii)(iii) as paragraphs (d)(3)(ii)(A) through (d)(3)(ii)(C), respectively.
11. In newly designated paragraph (d)(3)(iii), removing the language “*Example 2* of this paragraph (d)(2)” and adding the language “paragraph (d)(3)(ii) of this section (*Example 2*)” in its place.
12. Revising paragraph (h);
13. Revising paragraphs (l)(1) and (l)(2)(i); and
14. Revising paragraph (n)(1), revising the first sentence of paragraphs (n)(2) and (3), and adding paragraphs (n)(5) and (6).

The revisions and additions read as follows:

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

* * * * *

(c) * * *

(1) *In general.* Except as provided in paragraphs (c)(6) and (7) of this section, a month is a coverage month for an individual if—

(i) As of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange;

(ii) The taxpayer pays the taxpayer's share of the premium for the individual's coverage under the plan for the month by the unextended due date for filing the taxpayer's income tax return for that taxable year, the full premium for the month is paid by advance credit payments, or the amount of the premium paid (including by advance credit payments) for the month is sufficient to avoid termination of the individual's coverage for that month under one of the scenarios described in paragraph (c)(4) of this section; and

(iii) The individual is not eligible for the full calendar month for minimum essential coverage (within the meaning of § 1.36B-2(c)) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

* * * * *

(6) *Verification requirements*—(i) *In general.* A month is not a coverage month for an individual enrolled in a qualified health plan if the Exchange through which the individual enrolled fails to verify—

(A) *Enrollment eligibility*—

(1) The individual's place of residence meets the applicable residency standard in 45 CFR 155.305(a)(3);

(2) The individual is a U.S. citizen, a national of the U.S., or an alien lawfully present in the U.S.; and

(B) *Advance credit payment eligibility.* For individuals for whom advance credit payments are made—

(1) The items in paragraph (c)(6)(i)(A) of this section;

(2) The household income and family size of the taxpayer who is expected to file an income tax return for the year of coverage reconciling the advance credit payments for the individual's coverage with the premium tax credit allowed for the coverage;

(3) That the individual is ineligible for minimum essential coverage, other than individual market coverage; and

(4) If the individual is an alien lawfully present in the U.S., that the individual is an eligible alien as defined in section 36B(e)(2)(B).

(ii) *Waiver of verification requirements.* Paragraph (c)(6)(i) of this section does not apply for an individual's months of coverage in a qualified health plan in a plan year with respect to the applicable enrollment information described in paragraph (c)(6)(i) of this section provided during a special enrollment period that is triggered by an event described in 45 CFR 155.420(d)(2)(i) or (ii).

(7) *Failure to reconcile status.* A month is not a coverage month for an individual for whom advance credit payments were made for the individual's qualified health plan coverage if the Exchange through which the individual enrolled failed to comply with section 36B(c)(6) for the month.

* * * * *

(d) * * *

(2) *Reduction for amounts allocable to individuals not lawfully present or not eligible aliens.* In determining the premium assistance amount in paragraph (d)(1) of this section for a taxpayer, if any individual in the taxpayer's family who is enrolled in a qualified health plan is not lawfully present or is an alien lawfully present but not an eligible alien, as defined in section 36B(e)(2)(B), the taxpayer must reduce the

enrollment premiums under paragraph (d)(1)(i) of this section and the adjusted monthly premium for the applicable benchmark plan under paragraph (d)(1)(ii) of this section by the portion of the premiums attributable to such individual.

* * * * *

(h) *Plan covering more than one family under a single policy—*(1) *In general.* If a qualified health plan covers more than one family under a single policy, each applicable taxpayer with a family member covered by the policy may claim a premium tax credit, if otherwise allowable. Each taxpayer computes the credit using that taxpayer's applicable percentage, household income, and the benchmark plan that applies to the taxpayer under paragraph (f) of this section. Except as provided in paragraph (h)(2) of this section, in determining whether the amount computed under paragraph (d)(1)(i) of this section (the enrollment premiums) is less than the amount computed under paragraph (d)(1)(ii) of this section (the benchmark plan premium minus the product of household income and the applicable percentage), the enrollment premiums are allocated to each taxpayer in proportion to the premiums for each taxpayer's applicable benchmark plan.

(2) *Allocation if an individual is not lawfully present or not an eligible alien—*(i) *In general.* Except as provided in paragraph (h)(2)(ii) of this section, if a qualified health plan covers more than one family under a single policy and one or more individuals covered by the policy is not lawfully present, or is a lawfully present alien but not an eligible alien, then this paragraph (h)(2)(i) is used to determine the portion of the enrollment premiums for the policy allocable to each taxpayer with a family member covered by the policy for purposes of determining whether the amount under paragraph (d)(1)(i) of this section is less than the amount under paragraph (d)(1)(ii) of this section, as adjusted by paragraph (d)(2) of this section. Under this paragraph (h)(2)(i), the portion of the enrollment premiums allocated to a taxpayer with a family member covered by the policy is the enrollment premiums for the policy multiplied by a fraction,

the numerator of which is the taxpayer's applicable benchmark plan premium, excluding individuals covered by the policy who are not lawfully present or who are lawfully present aliens but not eligible aliens, and the denominator of which is the amount the applicable benchmark plan premium would be if all of the individuals covered by the policy were treated as members of one coverage family, including individuals enrolled in the plan who are not lawfully present or who are lawfully present aliens but not eligible aliens.

(ii) Allocation if an individual is not lawfully present or not an eligible alien and an individual is not in the coverage family. If a qualified health plan covers more than one family under a single policy and one or more individuals covered by the policy is not lawfully present, or is a lawfully present alien but not an eligible alien, and one or more individuals covered by the policy is not in a coverage family because, for example, the individual is eligible for minimum essential coverage, this paragraph (h)(2)(ii) is used to determine the portion of the enrollment premiums for the policy allocable to each taxpayer with a family member covered by the policy for purposes of determining whether the amount under paragraph (d)(1)(i) of this section is less than the amount under paragraph (d)(1)(ii) of this section as adjusted by paragraph (d)(2) of this section. For purposes of this paragraph (h)(2)(ii), the amount of the enrollment premium to be allocated (the net allocable premium) equals the enrollment premium for the policy multiplied by a fraction, the numerator of which is the amount the applicable benchmark plan premium would be if all of the individuals covered by the policy were treated as members of one coverage family, excluding individuals covered by the policy who are not lawfully present or who are lawfully present aliens but not eligible aliens, and the denominator of which is the amount the applicable benchmark plan premium would be if all of the individuals covered by the policy were members of one coverage family, including individuals covered by the policy who are not lawfully present or who are

lawfully present aliens but not eligible aliens. The net allocable premium is then allocated to a taxpayer with a family member covered by the policy by multiplying the net allocable premium by a fraction, the numerator of which is the applicable benchmark plan premium for the taxpayer's coverage family, excluding individuals covered by the policy who are not lawfully present or who are lawfully present aliens but not eligible aliens, and the denominator of which is the amount the applicable benchmark plan premium would be if the members of the coverage families covered by the policy were treated as members of a single coverage family, excluding individuals covered by the policy who are not lawfully present or who are lawfully present aliens but not eligible aliens.

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

(i) *Example 1.* (A) Taxpayers A and B enroll in a qualified health plan under a single policy. B is A's 25-year old child who is not A's dependent. B has no dependents. The plan covers A, B, and A's two additional children who are A's dependents. The enrollment premium for the policy is \$15,000. The applicable benchmark plan premium for A's coverage family of A and A's dependents is \$12,000. The applicable benchmark plan premium for B's coverage family, which includes only B, is \$6,000. A and B are applicable taxpayers and otherwise eligible to claim the premium tax credit.

(B) Under paragraph (h)(1) of this section, both A and B may claim a premium tax credit. A computes her credit using her household income, a family size of three, and a benchmark plan premium of \$12,000. B computes his credit using his household income, a family size of one, and an applicable benchmark plan premium of \$6,000.

(C) In determining whether the amount in paragraph (d)(1)(i) of this section (the enrollment premiums for the taxpayer) is less than the amount in paragraph (d)(1)(ii) of this section (the benchmark plan premium for the taxpayer minus the product of household income and the applicable percentage), the \$15,000 enrollment premium for

the policy is allocated to A and B in proportion to the premiums for their applicable benchmark plans. Thus, the portion of the enrollment premium allocated to A is \$10,000 ($\$15,000 \times \$12,000/\$18,000$) and the portion allocated to B is \$5,000 ($\$15,000 \times \$6,000/\$18,000$).

(ii) *Example 2.* (A) Taxpayers C and D enroll in a qualified health plan under a single policy. D is C's 25-year old child and is not C's dependent. The plan also covers C's spouse and D's child who is a dependent of D. C, D, and D's child are U.S. citizens and C's spouse is lawfully present in the U.S. but not an eligible alien as defined in section 36B(e)(2)(B). The enrollment premium for the policy is \$14,000. The applicable benchmark plan premium for C's coverage family is \$5,500, which under paragraph (d)(2) of this section does not include the cost of covering C's spouse because C's spouse is an alien lawfully present in the U.S. but not an eligible alien. The applicable benchmark plan premium for D's coverage family of D and D's child is \$7,150. If all of the individuals enrolled in the plan were treated as members of one coverage family, the applicable benchmark plan premium including C's spouse, who is an alien lawfully present but not an eligible alien, would be \$15,400. C and D are applicable taxpayers and otherwise eligible to claim the premium tax credit.

(B) Under paragraph (h)(1) of this section, both C and D may claim a premium tax credit. Because C's family and D's family are enrolled in the qualified health plan under a single policy and C's spouse, an alien lawfully present in the U.S. but not an eligible alien, is enrolled in the plan, paragraph (h)(2)(i) of this section applies to determine the enrollment premium for the policy C and D use in determining whether the amount in paragraph (d)(1)(i) of this section is less than the amount in paragraph (d)(1)(ii) of this section as adjusted by paragraph (d)(2) of this section. Under paragraph (h)(2)(i) of this section, C's enrollment premium is \$5,000 ($\$14,000 \times \$5,500$ (C's applicable benchmark plan premium)/\$15,400 (the applicable benchmark plan premium

for all of the individuals enrolled in the plan, including C's spouse, if treated as members of one coverage family)). Under paragraph (h)(2)(i) of this section, D's enrollment premium is \$6,500 ($\$14,000$ (enrollment premium for the plan) $\times$ $\$7,150$ (D's applicable benchmark plan premium)/ $\$15,400$ (the applicable benchmark plan premium for all of the individuals enrolled in the plan, including C's spouse, if treated as members of one coverage family)).

(iii) *Example 3.* (A) The facts are the same as in paragraph (h)(3)(ii) of this section (*Example 2*) except that D's child is eligible for minimum essential coverage and therefore not a member of D's coverage family. Thus, paragraph (h)(2)(ii) of this section applies to determine the enrollment premiums that C and D use in determining whether the amount in paragraph (d)(1)(i) of this section is less than the amount in paragraph (d)(1)(ii) of this section as adjusted by paragraph (d)(2) of this section. If all of the individuals enrolled in the plan were treated as members of one coverage family, the applicable benchmark plan premium, excluding individuals enrolled in the plan who are not lawfully present or who are lawfully present aliens but not eligible aliens, would be \$12,650, which includes all individuals enrolled in the plan except C's spouse, who is an alien lawfully present in the U.S. but not an eligible alien. The applicable benchmark plan premium for D's coverage family is \$4,400, which does not include the cost of covering D's child, who is eligible for minimum essential coverage and thus not includible in D's coverage family. If the members of the coverage families enrolled in the plan were treated as members of a single coverage family, the applicable benchmark plan premium, excluding individuals enrolled in the plan who are not lawfully present or who are lawfully present aliens but not eligible aliens, would be \$9,900, which excludes both D's child and C's spouse.

(B) Under paragraph (h)(1) of this section, both C and D may claim premium tax credits. The net allocable premium for the plan is \$11,500 ($\$14,000$ (enrollment

premium for the plan) $\times$ \$12,650 (the applicable benchmark plan premium for all of the individuals enrolled in the plan, excluding C's spouse who is an alien lawfully present in the U.S. but not an eligible alien, if treated as members of one coverage family)/\$15,400 (the applicable benchmark plan premium for all of the individuals enrolled in the plan, including C's spouse, if treated as members of one coverage family)). Under paragraph (h)(2)(ii) of this section, C's enrollment premium is \$6,389 ($\$11,500$ (net allocable enrollment premium) $\times$ $\$5,500$ (C's applicable benchmark plan premium)/ $\$9,900$ (the total of C's and D's applicable benchmark plan premium)). Under paragraph (h)(2)(ii) of this section, D's enrollment premium is \$5,111 ($\$11,500 \times \$4,400$ (D's applicable benchmark plan premium)/ $\$9,900$ (the total of C's and D's applicable benchmark plan premiums)).

* * * * *

(l) * * *

(1) *In general.* If one or more individuals for whom a taxpayer is allowed a deduction under section 151 are not lawfully present (within the meaning of § 1.36B-1(g)) or, in the case of aliens who are lawfully present, are not eligible aliens, the percentage a taxpayer's household income bears to the Federal poverty line for the taxpayer's family size for purposes of determining the applicable percentage under paragraph (g) of this section is determined by excluding from family size individuals who are not lawfully present, or, in the case of aliens who are lawfully present, are not eligible aliens, and by determining household income in accordance with paragraph (l)(2) of this section.

(2) * * *

(i) *Statutory method.* For purposes of paragraph (l)(1) of this section, household income is equal to the product of the taxpayer's household income (determined without regard to this paragraph (l)(2)) and a fraction—

(A) The numerator of which is the Federal poverty line for the taxpayer's family size determined by excluding individuals who are not lawfully present or, in the case of aliens who are lawfully present, are not eligible aliens; and

(B) The denominator of which is the Federal poverty line for the taxpayer's family size determined by including individuals who are not lawfully present or, in the case of aliens who are lawfully present, are not eligible aliens.

* * * * *

(n) * * *

(1) Except as provided in paragraphs (n)(2) through (6) of this section, this section applies to taxable years ending after December 31, 2013.

(2) Paragraphs (d)(1) (except for paragraph (d)(1)(i)) and (d)(3) of this section apply to taxable years beginning after December 31, 2016. * * *

(3) Paragraphs (c)(4), (5), and (8) of this section apply to taxable years beginning on or after January 1, 2025. * * *

* * * * *

(5) Paragraphs (c)(6) and (7) of this section apply to taxable years beginning after December 31, 2027.

(6) Paragraphs (d)(2), (h), (l)(1), and (l)(2)(i) of this section apply to taxable years beginning after December 31, 2026. Paragraphs (h), (l)(1), and (l)(2)(i) of this section as contained in 26 CFR part 1 edition revised as of April 1, 2025, applies to taxable years ending after December 31, 2013, and beginning before January 1, 2027.

Par. 5. Section 1.36B-4 is amended by revising paragraph (c) to read as follows:

§ 1.36B-4 Reconciling the premium tax credit with advance credit payments.

* * * * *

(c) *Applicability date*—

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

(2) The last sentence of paragraphs (a)(1)(ii)(B)(1) and (2), and (a)(1)(ii)(C) of this section apply to taxable years ending on or after December 31, 2020.

(3) Paragraph (a)(3) of this section applies to taxable years ending after December 31, 2013, and beginning before **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

Par. 6. Section 1.36B-5 is amended by:

1. Revising paragraphs (c)(1)(iv) and (viii);
2. Revising paragraph (c)(3)(iii)(B); and
3. Revising paragraph (h).

The revisions read as follows:

§ 1.36B-5 Information reporting by Exchanges.

* * * * *

(c) * * *

(1) * * *

(iv) For plans for which advance credit payments are made, the premium (excluding the premium allocated to benefits in excess of essential health benefits, see § 1.36B-3(j), and the premium allocable to individuals in the tax filer's family enrolled in the plan who are not lawfully present or, in the case of aliens who are lawfully present, are not eligible aliens) for the applicable benchmark plan for purposes of computing advance credit payments;

* * * * *

(viii) The monthly premium for the plan in which the individuals enroll, however—

(A) The premium allocated to benefits in excess of essential health benefits is excluded, see § 1.36B-3(j);

(B) For plans for which advance credit payments are made, the premium allocable to individuals in the tax filer's family enrolled in the plan who are not lawfully present or, in the case of aliens who are lawfully present, are not eligible aliens, is excluded;

(C) The premium for a stand-alone dental plan allocated to pediatric dental benefits is added, see § 1.36B-3(k), but if a family (within the meaning of § 1.36B-1(d)) is enrolled in more than one qualified health plan, the pediatric dental premium is added to the premium for only one qualified health plan; and

(D) The amount is not reduced for advance credit payments;

* * * * *

(3) * * *

(iii) * * *

(B) *Certain mid-month enrollments and terminations.* For information reporting that is due on or after January 1, 2019, if an individual's qualified health plan is terminated before the last day of a month, or if an individual is enrolled in coverage after the first day of a month and the coverage is effective on the date of the individual's birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order, the amount reported under paragraphs (c)(1)(iv) and (v) of this section is the premium for the applicable benchmark plan for a full month of coverage (excluding the premium allocated to benefits in excess of essential health benefits), and the amount reported under paragraph (c)(1)(viii) of this section is the enrollment premium for the month, reduced by any amounts that were refunded. However, for information reporting for coverage months in taxable years beginning after December 31, 2026, any amount of the premiums allocable to individuals in the tax filer's family enrolled in the plan who are not lawfully present or, in the case of aliens who are lawfully present, are not eligible aliens must be excluded from the amount reported under paragraph (c)(1)(iv) of this

section. In addition, for information reporting for coverage months in taxable years beginning after December 31, 2026, the amount reported as enrollment premiums for the month is the amount described under paragraph (c)(1)(viii) of this section, reduced by any amounts that were refunded and allocable to individuals in the tax filer's family enrolled in the plan who are lawfully present or, in the case of aliens who are lawfully present, are eligible aliens.

* * * * *

(h) Applicability date.

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

(2) Paragraph (c)(3)(iii) of this section applies to taxable years beginning after December 31, 2026. Paragraph (c)(3)(iii) of this section as contained in 26 CFR part 1 edition revised as of April 1, 2025, applies to taxable years beginning after December 31, 2018, and ending before January 1, 2027. The last sentence of paragraph (c)(3)(i) of this section applies to taxable years beginning after December 31, 2018. Section 1.36B-5(c)(3) as contained in 26 CFR part 1 edition revised as of April 1, 2016, applies to information reporting for taxable years ending after December 31, 2013, and beginning before January 1, 2019.

(3) Paragraphs (c)(1)(iv) and (viii) of this section apply to taxable years beginning after December 31, 2026. Paragraphs (c)(1)(iv) and (viii) of this section as contained in 26 CFR part 1 edition revised as of April 1, 2025, apply to taxable years ending after December 31, 2013, and beginning before January 1, 2027.

Frank J. Bisignano,

Chief Executive Officer.