

# State Health Reform Assistance Network

Charting the Road to Coverage

## POLICY BRIEF

June 2012

# Overview of Final Regulations on Health Insurance Premium Tax Credit

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## OVERVIEW

On May 18, 2012, the Internal Revenue Service (IRS) finalized regulations related to health insurance premium tax credits authorized by the Affordable Care Act (ACA) for certain lower-income individuals who enroll in qualified health plans (QHPs) through Exchanges.<sup>1</sup> In response to comments on the proposed rule suggesting that premium tax credits may not be available to those individuals who enroll through Federally-facilitated Exchanges (FFE), the preamble to the final rule confirms the availability of premium tax credits to individuals who enroll in QHPs through any of the Exchange models – State-based Exchanges, Partnership Exchanges and FFEs. The tax credit regulations, companion guidance to the Exchange and Medicaid eligibility regulations, finalize policies on eligibility for premium tax credits; provide additional operational details on the calculation of premium tax credits; and clarify and provide additional scenarios on application of these policies.<sup>2</sup> Although a final rule, the IRS is accepting public comments on the regulation until August 21, 2012.

## TAKEAWAYS

### Eligibility for Government-Sponsored Minimum Essential Coverage (MEC)

The final rule confirms and expands on the proposed policy to allow individuals who have been determined eligible for government-sponsored MEC, such as Medicaid and the Children's Health Insurance Program (CHIP), sufficient time to complete the requirements to effectuate their government MEC. (Such requirements may include application filing, providing necessary documents, and selecting a health plan.) The final rule provides a more generous timeframe of three months for an individual to complete government-sponsored coverage activation. This "grace period" allows consumers to retain time limited eligibility for premium tax credits until they are able to activate their government-sponsored MEC. The commentary also points to the final Exchange regulation policies that help to align the termination of qualified health plan coverage (and liability for advance payment tax credits) with Medicaid/CHIP coverage activation.

<sup>1</sup> "Health Insurance Premium Tax Credit," *Internal Revenue Service*, 77 Fed Reg 30377

<sup>2</sup> "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," *Department of Health and Human Services*, 77 Fed Reg 18310; "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," *Department of Health and Human Services*, 77 Fed Reg 17144

## ABOUT THE PROGRAM

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit [www.statenetwork.org](http://www.statenetwork.org).

## ABOUT MANATT HEALTH SOLUTIONS

Manatt Health Solutions (MHS) is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. MHS helps clients develop and implement strategies to address their greatest challenges, improve performance and position themselves for long-term sustainability and growth.

## ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measureable and timely change. For nearly 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit [www.rwjf.org](http://www.rwjf.org).

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**Affordability of Employer Sponsored Insurance (ESI)**

The final rule includes additional information related to assessing the affordability of available employer-sponsored coverage, but notably defers providing guidance on the determination of whether affordable, employer-sponsored coverage is available to an employee's family. Under the proposed rule, affordability of employer coverage for individuals related to an employee would be determined based on the costs of coverage for the individual employee only, disregarding additional costs of family coverage. This rule generated significant concern that low income families would remain without access to affordable health insurance coverage in 2014. The final rule is revised to address only affordability of an individual employee's coverage – that is, affordability tested on whether the premiums for self-only coverage exceed 9.5% of household income for the employee, and reserves a section in the regulatory code to address the determination of affordability for related individuals in future guidance.

The final rule also defers to future guidance the treatment of wellness incentives and employer contributions to health reimbursement arrangements (HRAs) in determining affordability of employer-sponsored coverage. However, the preamble commentary notes that amounts available under an HRA that may be used to reimburse medical expenses other than the employee's required share of the cost of employer-sponsored coverage would not affect the affordability of employer-sponsored coverage. IRS seeks comments on the effect of wellness incentives that increase or decrease an employee's share of premium on affordability. Specifically, IRS seeks comments on types of wellness incentives, how these programs affect the affordability for eligible employer-sponsored coverage for employees and related individuals, and how incentives are earned and applied.

**Marriage Rule**

The final rule provides two options for when taxpayers marry during the taxable year in the calculation of premium tax credits, adopting a computation methodology suggested by commenters that would generally result in a smaller amount of excess advance payment.

**Future Guidance**

Similar to the Exchange and Medicaid eligibility regulations, the final IRS rule highlights a number of areas in which to expect future guidance. These include:

- Treatment of Limited Benefits Programs under government sponsored and other Minimum Essential Coverage (MEC);
- Treatment of related individuals in determining affordability of ESI;
- Treatment of wellness programs and health reimbursement arrangements;
- Calculation of minimum value; and
- Reporting requirements.

**SUMMARY: MINIMUM ESSENTIAL COVERAGE, PREMIUM ASSISTANCE COMPUTATION AND INFORMATION REPORTING**

The ACA allows for advanceable and refundable premium tax credits and cost sharing reductions to help individuals and families purchase QHP coverage in Exchanges. The tax credits are designed on a sliding scale basis to reduce taxpayers' out-of-pocket premium costs, thus making health insurance coverage more affordable. The ACA further provides for determination of tax credit eligibility by State Exchanges. Taxpayers may receive advance payments of credits, paid on a monthly basis to the QHP in which they are enrolled. The law specifies that advance payments will be reconciled with actual credits for the tax year.

**Premium Tax Credit Definitions*****Family and Family Size (IRS §1.36B-1 (d))***

The final rule codifies the definition of "family" for the purposes of calculating the premium tax credit as the individuals for whom the taxpayer properly claims a dependency exemption deduction. Commentary in the final rule notes that children not claimed as dependents by the taxpayer may not be included but that the non-dependent child may claim a premium tax credit separately if eligible. The final regulation also clarifies that the family includes individuals who are exempt under Section 5000A from the requirement to maintain minimum essential coverage.

***Modified Adjusted Gross Income (IRS §1.36B-1 (e)(2))***

The final rule conforms the definition of “modified adjusted gross income” to include Social Security benefits, as added by the 3% Withholding Repeal and Job Creation Act (P.L. 112-56). “Modified adjusted gross income” means adjusted gross income increased by foreign-earned income, tax-exempt interest received or accrued by the taxpayer, and Social Security benefits.

***Lawfully Present (IRS §1.36B-1 (e)(2))***

The final rule cross-references and aligns the definition of “lawfully present” included in the final Exchange regulations.

***Federal Poverty Line (IRS §1.36B-1 (h))***

The Federal poverty line (FPL) applied when computing the premium tax credit is the FPL in effect as of the first day of initial or annual open enrollment. Alaska and Hawaii have separate FPLs from the contiguous United States. The final rule clarifies that if the taxpayer’s residence changes from one state to another, or married taxpayers reside in separate states, with different FPLs, the higher FPL (i.e., lower percentage of poverty calculation) applies.

***Rating Area (IRS §1.36B-1 (h))***

The applicable benchmark plan in computing the premium tax credit is the second lowest cost silver plan in the rating area where the taxpayer resides. While the proposed rule aligned the definition of rating area with the Exchange “service area,” the final rule strikes this definition and defers defining “rating area,” reserving a section of the code to provide additional guidance.

**Government-Sponsored Minimum Essential Coverage**

***Definition of Eligibility for Government-Sponsored MEC (IRS §1.36B-2 (c)(2)(iii)(A))***

The final rule provides that individuals are deemed eligible for government-sponsored MEC on the first day of the first full month in which they may receive benefits. The implications of this eligibility definition are significant in that individuals who are determined eligible for government coverage, but who have not yet completed the activation of their coverage, remain eligible for premium tax credits until they are able to use their government-sponsored health insurance. The final rule extends the timeframe for activation of government-sponsored MEC (including health plan selection, if required): individuals who fail to complete requirements within three months of the event that establishes their eligibility for government sponsored MEC are treated as eligible on the first date of the fourth calendar month following the eligibility event.

***Interaction Between Retroactive Medicaid Coverage and Premium Assistance Payments (IRS §1.36B-2 (c)(2)(iii)(B))***

The final rule adopts the policy that individuals receiving advance premium credit payments who subsequently become eligible for government-sponsored MEC that is effective retroactively (e.g., Medicaid) are treated as eligible for the government-coverage no sooner than the first day of the first calendar month after the approval.

***Eligibility for Limited Benefits (IRS Regulation Preamble §2(C))***

Commentary to the final rule notes that forthcoming regulations on MEC will likely provide that government-sponsored health benefit programs that offer only very limited benefits (e.g., family planning services under Medicaid) are not considered MEC.

**Employer-Sponsored Minimum Essential Coverage**

The final rule codifies the ACA provision that employees and related individuals who may enroll in an “eligible employer sponsored plan” – meaning a plan that is both affordable and meets a minimum actuarial value standard – are eligible for minimum essential coverage and therefore ineligible for premium tax credits.

***Definition of Employer-Sponsored MEC Plan Year (IRS §1.36B-2 (c)(3)(ii))***

The final rule defines the plan year as the employer-sponsored plan’s regular 12-month coverage period, or the remainder of the coverage year for employees who enroll during a special enrollment period.

***Definition of Eligibility for Coverage Months During a Plan Year (IRS §1.36B-2 (c)(3)(iii))***

The final rule defines eligible coverage months under employer-sponsored MEC as any month during the plan year for which the employee or related individual could have been covered if he or she had enrolled in an open or special enrollment period. Pursuant to the examples provided in the rule, this means that if an employee or related individual forgoes enrollment in an eligible employer-sponsored plan, he or she is deemed ineligible for premium tax credit payments.<sup>3</sup> The commentary notes that this is true even in cases where the employers' enrollment period has closed. The final rule adds an important clarification that the employee or related individual is not considered eligible for MEC when he/she is observing a required waiting period before coverage becomes effective.

***Affordability Test For Employer-Sponsored MEC (IRS §1.36B-2 (c)(3)(v)(A)(1)) and Affordability for Related Individuals (IRS §1.36B-2 (c)(3)(v)(A)(2))***

Pursuant to the ACA, employees who have access to employer-sponsored coverage may decline enrollment and apply for premium assistance to purchase a QHP in the Exchange if their out-of-pocket premiums for the employer plan exceed 9.5% of their household income. In response to comments, the final rule adopts the basis for this affordability calculation as the cost of *self-only coverage* and applies it to the employee only. This provision has been a significant focus of advocates, since the proposed rule deemed the employer plan affordable to an employee and his/her family if the cost of self-only coverage was less than 9.5%, likely resulting in some families remaining without access to affordable health insurance coverage in 2014. The final rule reserves a section in the regulatory code to address the determination of ESI affordability for related individuals in future guidance.

***Employee and Employer Safe Harbor (IRS §1.36B-2 (c)(3)(v)(A)(3))***

The final rule provides a safe harbor for employees who were offered eligible employer coverage that proves to be affordable based on household income for the taxable year, but who declined such coverage because it was deemed unaffordable by the Exchange at the time of enrollment. The safe harbor extends from the time of affordability determination until the end of the employer plan year; therefore, this timeframe may represent part-year periods and partially coincide or overlap with the taxable year for premium tax credits. The final rule adds three clarifications to this policy: (1) the safe harbor does not apply if the taxpayer "with reckless disregard for the facts" provides incorrect information to the Exchange concerning an employee's portion of the annual premium; (2) the safe harbor is not automatically extended should new or different employer-sponsored coverage become available during the plan year – the taxpayer must notify the Exchange and request a new affordability determination; and, (3) the safe harbor is not automatically extended at re-determination for tax credit eligibility – the taxpayer must provide information on the upcoming year of available employer-sponsored coverage for the Exchange to conduct the affordability determination.

***Wellness Incentives and Employer Contributions to Health Reimbursement Arrangements (IRS §1.36B-2 (c)(3)(v)(A)(4))***

The final rule defers to future guidance the treatment of wellness incentives and employer contributions to HRAs with respect to determining affordability of employer-sponsored coverage. However, the preamble commentary notes that amounts available under an HRA that may be used to reimburse medical expenses other than the employee's required share of the cost of employer-sponsored coverage would not affect the affordability of employer-sponsored coverage. IRS seeks comments on the effect of wellness incentives that increase or decrease an employee's share of premium on affordability. Specifically, IRS seeks comments on types of wellness incentives, how these programs affect the affordability for eligible employer-sponsored coverage for employees and related individuals, and how incentives are earned and applied.

***Affordability for Part-Year Period (IRS §1.36B-2 (c)(3)(v)(B))***

The final rule clarifies that affordability for employment periods that span less than full calendar years or portions of employers' plan years falling in different taxable years is determined separately for each part-year period. The determination will be performed by annualizing the employee's required contribution for the part-year period and comparing it to the required contribution percentage of the applicable taxpayer's household income for the taxable year.

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<sup>3</sup> The rule clarifies a special rule for individuals who are eligible for continuation coverage (COBRA) as eligible for MEC only if the individual actually enrolls in such coverage. The availability of COBRA coverage does not constitute eligibility for MEC, only the enrollment in such coverage does.

***Minimum Value (IRS §1.36B-2 (c)(3)(vi))***

The final rule codifies the ACA requirement that eligible employer-sponsored plans provide minimum value, defined as a plan share of at least 60% of the total allowed costs of benefits. IRS issued Notice 2012-31 (2012-20-IRB 906) to solicit comments on approaches for determining minimum value and indicates in the commentary that it will issue additional guidance.

***Enrollment in Eligible Employer-Sponsored Plan (IRS §1.36B-2 (c)(3)(vii))***

Proposed regulations provide that individuals who enroll in an eligible employer sponsored plan are ineligible for premium tax credits even if the plan is unaffordable or fails to offer minimum value. In response to comments received on the proposed rule, the final rule clarifies that an individual who terminates such coverage is treated as eligible for MEC only for the months enrolled, not for the entire plan year. The final rule also provides additional protection for individuals who are auto-enrolled into an employer-sponsored plan that is unaffordable or fails to meet minimum value, in that such coverage will not be considered MEC if the individual terminates enrollment before the later of the first day of the second full calendar month of the plan year or the last opt-out period provided by the employer-sponsored plan.

**Computing The Premium Assistance Credit Amount**

The final rule provides detailed guidance regarding the definition of and method for calculating premium tax credits. The rule defines a taxpayer's premium tax credit as the sum of "premium assistance amounts" for each coverage month in the taxable year. At the System-wide Health Insurance Exchanges meeting held in Washington, DC in late May, HHS and IRS announced the development of a maximum premium tax credit calculator that Exchanges will be required to use as part of their business process for premium tax credit determination and calculation.

***Definition of Coverage Month (IRS §1.36B-3 (c))***

The final rule defines a coverage month if: the individual is enrolled in a QHP as of the first of the month; the premium is paid for by the taxpayer or premium tax credits; and the individual is not eligible for MEC for at least one day during the coverage month.

***Premium Assistance Amount (IRS §1.36B-3 (d))***

The final rule provides the method for calculating premium assistance amounts. Such method is based on a number of factors including: household income, family size, "applicable percentage" (the taxpayer's required share of premiums based on household income), the "benchmark plan premium" (the premium for the second lowest cost silver plan in the Exchange for the coverage family), and the premium for the plan in which the taxpayer enrolls. The preamble to the regulation noted comments to the proposed regulation that suggested allowing taxpayers to determine the premium tax credit by combining QHP premiums with premiums a taxpayer pays for other minimum essential coverage, including CHIP. The IRS declined to revise the methodology for computing premium assistance amounts to include premiums for other, non-QHP coverage.

***Premiums Paid on a Taxpayer's Behalf (IRS §1.36B-3 (c)(2))***

The final rule notes that premiums paid by another person for coverage of the taxpayer, taxpayer's spouse or dependent are treated as paid by the taxpayer. Examples clarify that in cases where another person pays premiums on behalf of a taxpayer or taxpayer's family, the tax credit still is claimed by and accrues to the benefit of the taxpayer.

***Adjusted Monthly Premium (IRS §1.36B-3 (e))***

The final rule defines the adjusted monthly premium as the amount the issuer would charge for the applicable benchmark plan to cover all members of the coverage family, adjusted for age of each member of the coverage family. The final rule also codifies a statutory provision that the adjusted monthly premium be determined without regard to any premium discount or rebate under a wellness discount demonstration project under §2705(d) of the Public Health Service Act and may not include adjustments for tobacco use. In the System-wide Health Insurance Exchange meeting held in Washington DC in late May, several states noted that the adjustment methodology for benchmark plan premiums has a negative impact for low-income smokers, because the adjusted rate (based on age only) used to calculate their maximum premium tax credit will be lower than their actual QHP rate, which will be adjusted for their tobacco use. IRS staff noted the concern, and pointed to still forthcoming rating rules as potentially addressing this issue.

***Applicable Benchmark Plan (IRS §1.36B-3 (f))***

A taxpayer's premium tax credit amount is calculated off the second lowest cost silver plan offered by the Exchange in the rating area where the taxpayer resides. The final rule stipulates that the applicable benchmark plan: (i) covers the coverage family; (ii) may be self-only coverage or family coverage; and, (iii) must be open for enrollment to the taxpayer family at the time the taxpayer enrolls in a QHP. The applicable benchmark plan is a month-to-month determination and may change as a result of changes in the coverage family (e.g. a birth, death, or member of the coverage family gaining access to MEC). Thus, reported and unreported changes to an individual's eligibility status may have implications for the entire coverage family. Several examples are included in the final rule to illustrate the selection of the applicable benchmark plan.

***Families Not Covered by One Applicable Benchmark Plan (IRS §1.36B-3 (f))***

The final rule acknowledges that there may be situations in which no single benchmark plan covers an entire coverage family. The final rule provides that in these cases, premium for the applicable benchmark is the sum of the combination of premiums for the second lowest cost silver option that covers the entire coverage family. IRS reserves a section in the regulatory code to provide guidance for calculation of benchmark for a taxpayer's coverage family that is not covered under a single plan because they reside in different rating areas. The commentary notes that comments to the proposed regulations recommended that domestic partners and other two-adult groups should be permitted to use a family benchmark plan to compute their premium tax credit; however, the IRS does not adopt this policy noting that if the adults constitute two separate tax households, a separate credit computation is required.

***Applicable Percentage (IRS §1.36B-3 (g))***

The final rule codifies the ACA sliding scale used to determine the taxpayer's required share of premiums for the benchmark plan. The percentage scale, ranging from 2% of income for families with incomes less than 133% of FPL to 9.5% for families with incomes over 300% of FPL, is applied to the taxpayer's household income. The required share is subtracted from the adjusted monthly premium in calculating the premium assistance amount.

***QHP Covering More than One Family (IRS §1.36B-3 (h))***

The final rule stipulates that if a QHP covers more than one family (i.e., more than one taxpayer and his/her dependents) under a single policy the applicable taxpayers covered by the plan may each claim a premium tax credit. The rules articulate a specific method for calculating the premium credit amount in this circumstance.

***Additional Benefits (IRS §1.36B-3 (j))***

The final rule provides that the monthly premium for the purposes of premium assistance calculation be adjusted when a QHP offers benefits in addition to the essential benefit package – either voluntarily or as a result of a State mandate. In such circumstances, the final rule requires the portion of the premium that is allocable to these additional benefits be excluded from the monthly premiums used to calculate premium assistance amounts with the premium allocation methodology to be specified in further guidance by the HHS Secretary. Additional examples are included in the final rule to illustrate these adjustments.

***Pediatric Dental Coverage (IRS §1.36B-3 (f))***

For individuals enrolled in both a QHP and a dental plan, the portion of the dental plan attributable to pediatric dental benefits constituting essential health benefits are treated as premiums paid to the QHP for the purposes of calculating the adjusted monthly premium. The proposed rule requested comments on how to properly allocate the premium amount for pediatric dental benefit. The final rule provides that the HHS Secretary will issue additional guidance and the commentary notes that such guidance is likely to require QHP issuers to report on the portion of the premium allocable to pediatric dental coverage.

***Families Including Individuals Not Lawfully Present (IRS §1.36B-3 (k))***

The final rule provides guidance with respect to determining household income in taxpayer families that include individuals who are not lawfully present, but for whom the taxpayer properly claims a tax deduction. The rules provide a revised household income computation method which excludes the non-lawfully present individual from family size. While commenters suggest adoption of a comparable method based on the Medicaid rules for income and family size determinations, the final rule defers this decision and provides that the IRS Commissioner may issue additional guidance.

## **Reconciling The Premium Tax Credit With Advance Payments (IRS §1.36b-4)**

The final rule outlines the process and general parameters by which advance credit payments are reconciled with allowable tax credits based on a taxpayer's income tax return for the taxable year. The final regulations require that the actual premium tax credit is calculated at the end of the taxable year using the taxpayer's household income and family size for the taxable year. If this tax year-end process produces a premium tax credit for the year that exceeds the taxpayer's advance credit payments, he/she is eligible to receive the excess in the form of an income tax refund. Conversely, a taxpayer whose advance payments exceed the allowable tax credit for the taxable year will owe the excess to the IRS as an income tax liability. While these additional taxes are capped for taxpayers with household incomes under 400% FPL, the liability is potentially significant, up to \$2,500 for a taxpayer with household income between 300% and 400% FPL. Taxpayers with incomes over 400% of FPL are liable to return the full advance tax credit overpayment. Several commenters requested safe harbors and additional limitations on limitation but these were not adopted. Commenters also suggested for IRS offer automatic payment plans for taxpayers with additional tax liabilities and the commentary in the final rule notes that IRS will consider possible avenues of administrative relief.

### ***Responsibility for Advance Credit Payments (IRS §1.36B-4 (a)(1)(ii))***

The final rule stipulates that a taxpayer must reconcile advance credit payments for coverage of any member of the taxpayer's family for whom the taxpayer claims, or attests intent to claim, a personal exemption deduction.

### ***Advance Credit Payment for a Month in Which an Issuer Does Not Provide Coverage (IRS §1.36B-4 (a)(1)(iii))***

The final rule and commentary in the final rule explains the reconciliation that must be undertaken by the taxpayer if he/she fails to pay premiums in full for three months. The Exchange final regulations provide the taxpayer with a three-month grace period but allow the Exchange to terminate coverage retroactive to the end of the first month of the grace period. The final rule clarifies that the taxpayer does not have an advance payment tax credit for a month where coverage was not provided and is not be required to reconcile payments for terminated months without coverage.

### ***Changes in Filing Status, Taxpayers Who Marry During the Taxable Year (IRS §1.36B-4 (b)(2))***

The final rule provides two options for newly-married taxpayers in the calculation of premium tax credits, adopting a computation methodology suggested by commenters that would generally result in a smaller amount of excess advance payment. These taxpayers may either compute their premium tax credits: (1) using the family size and household income as reported on their tax return, regardless of whether the taxpayers were married or single during the month; or (2) separately for the single months – as if the taxpayer's annual income was one-half of the actual household income for the year – and using the actual household income for the year for the married months.

## **Information Reporting By Exchanges (IRS §1.36 B-5)**

The final rule outlines reporting requirements of Exchanges with respect to information reporting related to premium tax credit. Exchanges are required to report to the IRS taxpayers' information, including:

- The premium(s) for the applicable benchmark plan(s) used to calculate advance credit payments;
- The period the coverage was in effect;
- The total premium for the coverage without the reduction of advance credit payments and consumer cost sharing;
- The aggregate amount of advance credit payments or cost sharing reductions;
- The name, address and Social Security number (SSN) of the primary insured; and
- All information provided to the Exchange at the time of enrollment or during the taxable year, including changes in circumstances.

The final rule declines to add provisions requested by commenters to define and limit the use and disclosure of immigration status information.

The Commissioner of the Internal Revenue Service may promulgate guidance with respect to the timeframes and manner for this reporting. Finally, in the System-wide Health Insurance Exchanges meeting held in Washington DC in late May, the IRS indicated that information reporting by Exchanges with respect to premium tax credit information “would be a [federal data services] hub enabled process.”