

**Health Insurance Premium Tax Credit:
Summary of Final Rule
RIN 1545-BJ82
Internal Revenue Service, Treasury Department
May 25, 2011**

On May 23, 2012, the Internal Revenue Service (IRS) in the Treasury Department posted for publication in the *Federal Register* final rule implementing the Health Insurance Premium Tax Credit provisions of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (together, these laws are referred to by the Department as the Affordable Care Act (ACA)), along with several subsequent amendments to the laws. The final rules are effective May 23, 2012. Comments will be accepted until August 21, 2012.

A notice of proposed rulemaking (NPRM) was published in the *Federal Register* on August 17, 2011, and the final rule adopts those proposed regulations with changes as noted in this document. Three changes and comments of note include:

- Modified adjusted gross income now includes Social Security benefits, as required under P.L. 112-56).
- The IRS affirms and finalizes, in response to comments, the proposed definition of “Exchanges” for purposes of eligibility for premium tax credits to include a State Exchange, regional Exchange, subsidiary exchange, or Federally-facilitated Exchange.
- The IRS now “reserves” for future rulemaking the definition of affordable employer-sponsored minimum essential coverage in the case of families. In general, the proposed rule defined affordability for both employees and related individuals to mean that the annual premium for the employee for self-only coverage does not exceed a required contribution percentage, which is 9.5 percent of household income in 2014. That standard based on the premium for self-only coverage was proposed for both individual and family coverage, even if the premium for family coverage exceeded 9.5% of income. The final rule retains this standard for self-only coverage, but not for family coverage, and the IRS will address the affordability standard for family coverage in future rulemaking.

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BACKGROUND

Section 1401 of the ACA amended the Internal Revenue Code (Code) to add section 36B, which provides an advanceable and refundable premium tax credit to help individuals and families afford health insurance coverage through an Exchange.

EXPLANATION OF PROVISIONS AND SUMMARY OF COMMENTS

(Note: the final regulation includes an extensive set of specific examples that can be consulted to clarify the policies)

Premium tax credit definitions (§1.36B-1)

The final rule adopts the proposed definitions with clarifications in response to comments.

- Family size: The final rule clarifies that the computation of family size may include individuals who are exempt from the statutory requirement to maintain minimum essential coverage. The IRS retains the requirement that a child is included in the family size calculation only if the taxpayer is allowed a dependency exemption, because that is required under the statutory definition.
- Household income: The final rule clarifies the requirement to include in household income the income of a family member required to file a return, but excludes from that definition individuals required to file certain special types of returns required under the Code.
- Modified adjusted gross income: The final rule modifies the definition of gross income to include Social Security benefits, as required under the 3% Withholding Repeal and Job Creation Act (P.L. 112-56), which was enacted after the proposed rules were issued.
- Lawfully present: In order to maintain consistency with the Department of Health and Human Services (HHS), the final rule adopts the definition of “lawfully present” issued by HHS in the Exchange final rule. See 45 CFR 155.20.
- Federal poverty line: The final rule retains the reference to the poverty guidelines published annually by HHS. Because those guidelines include separate and higher guidelines for Alaska and Hawaii, the final rule clarifies that if married taxpayers reside in separate states the applicable guideline is the higher of the guidelines in their state of residence (resulting in that family being classified at a lower percentage of the Federal poverty line).
- Exchange/Federally-facilitated Exchange: The final rule retains the proposed definition of Exchange to include a State Exchange, regional Exchange, subsidiary Exchange, and Federally-facilitated Exchange. Some commenters had questioned whether premium tax credits would be available only in State Exchanges, but the IRS concludes that the statutory language and legislative history supports its definition of Exchange to include Federally-facilitated Exchanges.
- Rating area: The proposed rule defined rating area as an Exchange service area, as described in 45 CFR 155.20. In response to comments that an Exchange service area is different than a rating area, the final rule “reserves” the definition (the IRS neither adopts the proposed definition nor provides an alternative).

Eligibility for premium tax credit (§1.36B-2)

In general, eligibility is limited to those individuals who are:

- “Applicable taxpayers” and their spouses or dependents;
- Not eligible for minimal essential coverage through a government- or employer-sponsored plan or program; and
- Enrolled in one or more QHPs through an Exchange.

Applicable taxpayer

The final rule adopts the proposed rule definition of an applicable taxpayer: a taxpayer whose household income (modified adjusted gross income) is at least 100 percent but not more than 400 percent of the federal poverty line (FPL). If married, they must file a joint return. There are several special provisions.

If household income is less than 100 percent of the FPL, there are two provisions that still treat such a taxpayer as an “applicable taxpayer” for that year:

- If the individual is an alien lawfully present, and not eligible for Medicaid (due to the five-year waiting period), they can be treated as an “applicable taxpayer” if they would otherwise qualify for the tax credit.
- If the Exchange estimated at the time of enrollment that the taxpayer’s household income would be above 100 percent of the FPL, and high enough that the taxpayer is not eligible for Medicaid, and authorized payment of advance credits to a QHP in which the taxpayer enrolled, that taxpayer would be considered an applicable taxpayer even if actual household income for the taxable year was less than 100 percent of the FPL, so long as they would otherwise qualify for the tax credit.

The IRS responds to several comments asking that it broaden the definition, but does not revise the language.

The final rule also adopts the proposed language that if an individual is not lawfully present in the U.S., or is incarcerated, then that individual is not eligible to be covered by a QHP through an Exchange. However, such individuals may be considered “applicable taxpayers” if eligible family members enroll in a QHP.

Minimum essential coverage

The final rule adopts the proposed policy that a taxpayer is not eligible for the premium tax credit or enrollment in a QHP in a month if otherwise eligible for minimal essential coverage during that month through certain government- or employer-sponsored plans or grandfathered plans.

Government-sponsored minimum essential coverage: The final rule retains the definition of government-sponsored minimum essential coverage to include programs such as Medicare, Medicaid, CHIP, TRICARE and veteran's health care. As specified in the ACA, an individual is defined as eligible for minimum essential coverage under a veterans' health care program only if the individual is actually enrolled in the program. The final rule broadens the definition of eligibility for veterans programs to include individuals who are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (VA) or the VA spina bifida program.

Timing: The final rule adopts the proposed rule's policy that considers an individual as eligible for a government-sponsored program (other than a veteran's health care program, which requires enrollment) on the first day of the first full month in which the individual may receive benefits. However, the final rule clarifies the timing for applications. An individual does not lose eligibility for a tax credit if technically eligible for the government program for a month but not yet enrolled due to administrative processing. The proposed rule provided that if an individual failed to complete the application requirements "reasonably promptly," they would be treated as eligible for the government program as of the first day of the second month following the event that established eligibility. The final rule, in response to comments, makes two basic changes:

- It changes the proposed requirement for individuals to complete the application requirements "reasonably promptly" to a specific standard of the last day of the third full calendar month following the event that establishes eligibility.
- In such a case, it treats the individual as eligible for the government program on the first day of the fourth calendar month.

The IRS notes that the HHS final regulations on Exchanges address issues such as operational challenges arising from transitions from coverage under a qualified health plan to a government program.

In the case of an eligibility determination in a program such as Medicaid, where eligibility may be granted retroactively, and could overlap a period of receipt of advance payment premium tax credits, the final rule retains the proposed policy that the individual is treated as eligible for minimum essential coverage no sooner than the first day of the first calendar month after the approval. That means that the individual does not retroactively lose eligibility for the premium tax credit for the period of overlap when computing their end of year tax reconciliation. An individual is treated as not eligible for Medicaid, CHIP or a similar program if an Exchange determines that the individual is not eligible at the time that the individual enrolls in a QHP.

The final rule does not make changes in the proposed rule in response to comments that in the case of individuals with end-stage renal disease who become eligible for Medicare as a result of that diagnosis that eligibility be defined by actual enrollment (allowing them to remain enrolled in a QHP with the benefit of a tax credit instead). The IRS notes that such an interpretation is not consistent with statute.

In response to comments about the need to clarify whether eligibility for limited scope benefits (such as eligibility just for family planning services under Medicaid) constitutes eligibility for minimum essential coverage, the IRS notes that the definition of minimum essential coverage will address this issue.

Employer-sponsored minimum essential coverage: Minimum essential coverage includes an eligible employer-sponsored plan, including a grandfathered plan. An employee (and related individuals) who may enroll in the employer-sponsored plan is considered eligible for minimal essential coverage in a month if eligible to enroll in such a plan, even if they opt not to enroll.

To qualify as “minimum essential coverage” the plan must provide minimum value and be affordable.

Minimum value: The final rule retains the proposed policy that minimum value means that the plan’s share of total allowed costs of benefits is at least 60 percent. It notes that the IRS issued a Notice and Request for Comment on “Minimum Value of an Employer-Sponsored Health Plan” on April 30, 2012 on approaches for defining that minimum value.

Affordability: The proposed rule defined affordability for both employees and related individuals to mean that the annual premium for the employee for self-only coverage does not exceed a required contribution percentage, which is 9.5 percent of household income in 2014, and indexed for subsequent years. The IRS noted that this proposal meant that the plan is considered affordable (for the employee and related dependents) even if the employee’s required contribution for family coverage exceeds 9.5 percent of income. The IRS noted, however, that future regulations related to the affordability test for the individual mandate requirement for family members were expected to be based on the employee’s required contribution for family coverage.

In response to comments and concerns about applying that affordability standard to related individuals for family coverage, the final rule retains the proposed affordability standard for employee-only coverage, but “reserves” for future rulemaking the policy for affordability for related individuals (keeping open this major policy issue).

In response to comments, the IRS notes that contributions to health savings accounts (HSAs) do not impact the affordability calculation because they cannot be used to pay premiums. Likewise, amounts available under a health reimbursement account (HRA) that may be used to pay medical expenses other than the employee share of coverage would not affect the affordability calculation. However, the final rule indicates that the IRS may provide rules on how such amounts available through an HRA may be treated in determining affordability. In the same manner, in response to comments seeking clarification of how wellness incentive programs affect the determination of affordability, the final rule indicates that the IRS may provide rules in the future on how such wellness incentives may be treated. **The IRS requests comments on the types of wellness incentives, how they affect affordability, and how the incentives are earned and applied. It notes that any rule on wellness incentives must consider the extent**

to which employees can be certain they will qualify for the incentives at the time they are evaluated for eligibility for premium tax credits.

The final rule retains the proposed affordability safe harbor for employees, which provides that if an Exchange determines that an employer plan is unaffordable upon enrollment of the employee or related individual in a QHP in the Exchange, then that employer plan is considered to be unaffordable for the plan year, even if the taxpayer's final household income for the year would have made the plan affordable. Thus, the individual would not lose eligibility for any premium tax credit during that period. The final rule, however, provides that the safe harbor is not available to an individual who, "with reckless disregard for the facts, provides incorrect information to an Exchange..." Further, the IRS clarifies that it applies only until such time as the availability of employer-sponsored coverage changes, and that the affordability safe harbor does not carry over to later plan years automatically.

The final rule adopts the proposed policy that if an individual enrolls in an employer plan despite the fact that it would have been considered unaffordable, then the individual is considered to have minimum essential coverage (and thus ineligible to qualify for a tax credit in the Exchange). However, in response to comments, the final rule makes several clarifications to the policy:

- If such an individual terminates enrollment, the final rule clarifies that the individual is treated as eligible for minimum essential coverage only for the months that the individual is actually enrolled in such coverage.
- In the case of individuals who are automatically enrolled in such an employer-sponsored plan under default auto-enrollment processes, the final rule provides that such an individual will not be treated as having affordable minimum essential coverage if the individual terminates the coverage before the later of the first day of the second full calendar month of the plan year, or the last day of any permissible opt-out period provided by the plan or in regulations to be issued by the Department of Labor.

Failure to enroll in employer plan: The final rule adopts the policy that if an individual is eligible for coverage through an eligible employer-sponsored plan, and fails to enroll during a prescribed enrollment period, the individual is considered eligible for the minimal essential coverage under that plan throughout the plan year (and thus not eligible for a tax credit), even during the months when enrollment is no longer open.

Waiting periods: The final rule, in response to comments, clarifies that an individual is not treated as eligible for minimum essential coverage during a waiting period for eligibility for the employer plan.

Continuation coverage: The final rule adopts the following proposed policy for continuation coverage under federal or state law: an individual is considered eligible for minimum essential coverage only if the individual actually enrolls in such continuation coverage.

Non-dependent eligibility: The final rule clarifies the situation of an individual who may enroll in an employer-sponsored plan as a related individual, but who is not a tax dependent of the eligible individual (such as a 25-year old child or a domestic partner). In such cases, the final rule clarifies that such related individuals are treated as eligible for minimum essential coverage only for months in which they are actually enrolled in the employer coverage.

Computing the premium assistance credit amount (§1.36B-3)

The tax credit is an income-based credit designed to help make premiums more affordable.

- In general, for those with income between 100 percent and 400 percent of the FPL, it limits the taxpayer's share of the premium to an amount no greater than an applicable percentage of income. That percentage starts at two percent of income and increases to 9.5 percent of income for those between 300 percent and 400 percent of the FPL.
- That tax credit is calculated based on the premium for a benchmark plan, which is the second lowest priced "silver" plan available for that taxpayer's family enrollment category in the Exchange. If the taxpayer chooses a more expensive plan, the tax credit does not increase; it is a fixed amount and the taxpayer would then have to pay more out of pocket for the higher priced plan. If the taxpayer chooses the lowest price plan, the taxpayer pays a lower premium.
- The credit is paid by the government to insurers on a monthly basis for all "coverage months" for the taxpayer and family members, and reconciled, with limits, at the time the taxpayer files a tax return for the year.

The final rule adopts the proposed rule with several modifications noted below. In general, the taxpayer's premium assistance tax credit for a taxable year is the sum of the amounts of the credit for all coverage months for individuals in the taxpayer's family.

"Coverage family:" The final rule clarifies that coverage family refers to members of the taxpayer's family who enroll in a qualified health plan and who are not eligible for minimum essential coverage (other than in the individual market).

"Coverage month:" The final rule adopts with some modification the proposed definition of a coverage month, which has three components. It retains the language that a "coverage month" for an individual is a month in which the individual is covered by a QHP in the Exchange on the first day of the month. It modifies the proposed requirement that it is a month in which the individual is not eligible for minimum essential coverage on the first day of the month, and instead requires that the individuals not be eligible for minimum essential coverage on at least one day in the month. Finally, it clarifies that a coverage month is a month for which the premium is paid by an advance payment premium tax credit or by the taxpayer no later than the unextended due date for filing the taxpayer's tax return.

"Premiums paid for the taxpayer:" The final rule adopts the proposed policy that if another person pays for coverage for the taxpayer (such as a divorced parent paying for coverage for a child who is claimed as dependent by the other parent), that is considered a part of the premium

paid by the taxpayer, and the final rule confirms that payments made by an Indian tribe are treated as paid by the taxpayer.

Premium assistance amount

The final rule adopts the proposed policy that the amount of the premium assistance is the lesser of:

- The premium for the month for the QHP(s) in which the taxpayer and members of the taxpayer's family enroll; or
- The excess of: the adjusted monthly premium of the applicable benchmark plan over 1/12 of the taxpayer's household income times the applicable percentage for that income level for the tax year.

The adjusted monthly premium is the premium for the taxpayer's coverage family adjusted only for the age of each member as allowed under the ACA. The final rule clarifies that it is determined without regard to a discount or rebate under the wellness demonstration authorized in the individual market under the ACA, and does not include any adjustment for tobacco use.

Applicable benchmark plan

The final rule adopts the proposed policy that the benchmark plan for a coverage month is the second lowest cost "silver" plan (70 percent actuarial value) for self-only coverage, and for the applicable family size category for family coverage (with a technical clarification in the final rule).

In the case of silver plans that do not cover all members of a taxpayer's family (such as a dependent niece), with those dependents enrolling in a separate QHP, the final rule clarifies that the applicable benchmark plan and premium is the single premium or combination of premiums that is the second lowest cost silver option for covering the entire family.

The IRS does not adopt suggestions that the final rule should allow adults that constitute two households for federal tax purposes, such as domestic partners or other two-adult groups, to use a family benchmark plan to compute their premium tax credit if both adults can be covered by the same QHP.

The final rule "reserves" for future rulemaking the issue of how to determine the applicable benchmark plan for families with members living in different locations.

The final rule clarifies, in response to comment, that a QHP that is not open to enrollment by a taxpayer or family member at the time of enrollment is disregarded in determining the applicable benchmark plan for that taxpayer.

The final rule adopts the proposed policy that an applicable benchmark plan does not cease to be an applicable benchmark plan if that plan, or a lower cost plan, terminates or closes to enrollment during the taxable year.

Applicable percentage

The final rule adopts the proposed policy for the “applicable percentage,” which defines the taxpayer’s share of premiums for the benchmark plan. It determines, for each taxpayer’s income and family size as a percentage of the FPL, the share of income that must be spent on the premium, which is used to compute the tax credit amount based on the price of the benchmark plan. The applicable percentages are noted in the following table:

Applicable percentage table, 2014*		
Household income as percent of federal poverty line	Initial percentage**	Final percentage**
Less than 133%	2.0%	2.0%
At least 133% but less than 150%	3.0%	4.0%
At least 150% but less than 200%	4.0%	6.3%
At least 200% but less than 250%	6.3%	8.05%
At least 250% but less than 300%	8.05%	9.5%
At least 300% but less than 400%	9.5%	9.5%
*The applicable percentages may be increased in the future by statutory formula to reflect rates of premium growth compared with income (through 2018) and compared with the Consumer Price Index (CPI) (after 2018)		
**The percentage increases on a sliding scale between the initial and final percentage within each income category		

By way of example, HPA prepared the following calculation for the simplest of situations, using the 2012 FPL for a family of four, which is \$23,050:

- Taxpayer is a family of four, with income of \$34,575, which is exactly 150 percent of the FPL. The taxpayer’s applicable limit for purposes of computing the tax credit is 4.0% of income (see table), or $4\% * \$34,575 = \$1,383$ per year/\$115 per month (rounded).
- Assume taxpayer enrolls in the applicable benchmark plan (second lowest premium silver plan) for that family category, with a premium for that benchmark plan of \$12,000 per year, or \$1,000 per month.
- The policy sets the tax credit to pay the difference between the \$1,000 monthly premium for that applicable benchmark plan and the taxpayer’s obligation of \$115, or \$885 per month.
- If the taxpayer chooses a plan with a premium higher than the applicable benchmark plan (for example, a plan costing \$1,100 per month), the tax credit remains at \$885 per month, and the taxpayer is responsible for the remaining premium of \$215 (\$115 plus the extra \$100 for choosing a plan \$100 higher priced than the applicable benchmark plan).

- If the taxpayer chooses the lowest priced plan instead of the applicable benchmark plan (for example, a plan costing \$900 per month), the credit remains at \$885 per month, and the taxpayer is responsible for the just remaining \$15. However, even if the lower priced plan is less than the \$885 tax credit, the taxpayer share of premium can drop to zero, but never results in a rebate.

The final rule adopts the proposed policy for providing tax credits to applicable taxpayers when more than one applicable taxpayer is in a family unit covered under a QHP plan, and for prorating premiums to the applicable taxpayer for purposes of computing the tax credit. It provides examples of these computations.

Additional benefits

The final rule adopts the proposed policy that if the QHP offers benefits beyond the essential benefits, or a State requires such additional benefits, the portion of the premium attributable to those benefits is not included in the calculation of the premium for purposes of computing the tax credit, with the method of allocation determined under guidance to be issued by the Secretary of HHS.

Pediatric dental coverage

The final rule adopts, with clarification, the proposed policy in the case of an individual enrolled in a QHP and in the separate pediatric dental coverage allowed under the ACA. The portion of the premium for the separate dental coverage is added to the premium for the benchmark plan in computing the amount of the tax credit for that taxpayer. The proposed rule requested comments on the method of allocation, and final rule clarifies that the method of allocation is to be determined under guidance to be issued by the Secretary of HHS.

Families including individuals not lawfully present

The final rule adopts the proposed policy for computing the taxpayer's family size when there are individuals in the family who are not lawfully present. The computation of household income in that case is:

$$\text{Household income} \times \frac{\text{FPL for family size excluding individuals not lawfully present}}{\text{FPL for family size including individuals not lawfully present}}$$

The final rule provides that the Commissioner of the IRS may issue guidance for a comparable method in the future.

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

The final rule adopts, with several clarifications, the proposed policy that the amount of advance credit payments allowed over the course of a year based on the determinations of the Exchange is reconciled with the credit allowed based on the taxpayer's final income tax return for a taxable

year. The contribution amount (household income times the applicable percentage) is based on the household income and family size at the end of the taxable year.

The final rules clarify the situation for reconciliation of advance payments for taxpayers in the three month grace period provided under the Exchange final rule for those who do not pay the issuer their required share of the premiums. In general, in that situation, the issuer may terminate the taxpayer retroactive to the end of the first of the three months, and return to the Treasury any advance payment tax credits for those months. The taxpayer is not required to reconcile payment for those months in which coverage was terminated, but will have to reconcile payments for the advance payment tax credit for the first month. If the taxpayer does not pay their share of the premium for that first month by the due date for filing their tax return, then they are not eligible for any premium tax credit for that month.

The final rule adopts the policy that if the premium tax credit due for the taxable year exceeds the advance credit payments, then the taxpayer may receive the excess as an income tax refund. If the advance credit payments exceed the premium tax credit due for the year, the taxpayer owes the excess as a tax liability, subject to certain statutory limits for those with income less than 400 percent of the FPL. For 2014, the limits are as follows (they may be adjusted in future years to reflect changes in the CPI):

Additional tax limitation table, 2014		
Household income as percent of FPL	Limitation if filing as individual	Limitation for all other taxpayers
Less than 200%	\$300	\$600
At least 200% but less than 300%	\$750	\$1,500
At least 300% but less than 400%	\$1,250	\$2,500
400% or greater	No limit	

In cases where the family QHP coverage enrollment category changes over the course of a year (such as switching from coverage in a policy for two adults to coverage for two adults plus a child), which yields a change in the premium, benchmark and tax credit calculation, the rules generally determine the premium credit calculation based on the number of coverage months in each category.

Changes in filing status

In general, the final rule adopts the proposed policy that in cases where marital status changes, the taxpayer computes the applicable benchmark plan for the taxpayer’s marital status as of the first day in each coverage month; the taxpayer’s contribution amount is determined using the taxpayer’s household income and family size at the end of the taxable year.

In the case of taxpayers who marry during the taxable year, the final rule modifies the proposed policy by adopting an additional option to the monthly computation above. Under this alternative computation the credit for such taxpayers for their single months is computed separately for each taxpayer as if each taxpayer’s annual income was one-half of the actual

(combined) household income for the year; the credit for the married months is computed using the actual (combined) household income for the year; the premium tax credit for the year is the sum of the credits for the single and married months. The final rules cap any additional premium tax credit for a taxpayer at the amount of credit that results under the general rule.

In the case of taxpayers married at some time in the taxable year but no longer married at the end of the year, the final rule adopts the proposed policy. Such taxpayers must allocate, for any coverage months in which they were enrolled in the same QHP, the premium for the applicable benchmark plan, the plan in which they were jointly enrolled, and the advance credit payments in any portion they choose so long as the allocation for all items is the same. If the taxpayers cannot agree, 50 percent is allocated to each of the taxpayers.

The final rule adopts the proposed policy that married taxpayers must file joint returns in order to qualify for the premium tax credits. If a couple did receive advance credit payments but still file separately, they must allocate the advance credit payments equally to each spouse in determining the excess advance credit payments for purposes of reconciliation.

Information reporting by Exchanges (§1.36B-5)

The final rule adopts, with slight modifications, the proposed Exchange reporting requirements, under which Exchanges must report to the IRS and a taxpayer the following information for a QHP the taxpayer enrolls in:

- The premium for the applicable benchmark plan(s) used to compute advance credit payments, and the period coverage was in effect;
- The total premium for coverage in which the taxpayer or family member enrolls;
- The aggregate amounts of advance credit payments;
- The name, address and Social Security number (SSN) of the primary insured and the name and SSN or adoption taxpayer identification number (TIN) of the individuals covered under the policy;
- All information provided to the Exchange at the time of enrollment or during the taxable year necessary to determine eligibility for and the amount of the premium tax credit; and
- Any other information required in published guidance

The final rule “reserves” for future rulemaking the timeframe for information reporting by Exchanges.

Requirement of income tax return for taxpayers who claim the premium tax credit under section 36B (§1.6011-8)

Taxpayers who receive advance payments of premium tax credits must file an income tax return for that taxable year.