

Affordability of Employer Coverage for Family Members of Employees

A Proposed Rule by the Internal Revenue Service

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CC:PA:LPD:PR (REG-114339-21)
Room 5203, Internal Revenue Service
P.O. Box 7604
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Washington, DC 20044

**Re: Affordability of Employer Coverage for Family Members of Employees
IRS-2022-066, REG-114339-21, 87 Fed. Reg. 20,354**

To whom it may concern:

These comments are submitted on behalf of the American Public Health Association (APHA) and 63 individuals, commenting in their personal capacity, who are leading academic experts in the fields of public health and health policy. APHA champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. It represents more than 22,000 individual members and is the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health. The individual signers are nationally recognized scholars of public health and national health reform. Many possess extensive, detailed experience in analyzing, and conducting research in connection with, the Patient Protection and Affordable Care Act (the "Affordable Care Act" or ACA). Others are leading experts in health insurance research as it relates to coverage, access to care, and health outcomes. Included in this individual group are 18 deans, 7 department chairs, and 38 scholars, from a total of 31 educational institutions, listed in the attached Appendix A.

We strongly support the agency's effort to address the so-called "family glitch," which has barred many low- and moderate- income families from obtaining affordable health coverage. Specifically, the agency has proposed to revise its existing regulations governing eligibility for the premium tax credits that are available to individuals and families under the Affordable Care Act. Under this revision, the affordability of employer-sponsored coverage for family members will be determined "based on the employee's share of the cost of covering the employee and those family members, not the cost of covering only the employee."¹ Additionally, the proposed regulations would establish a minimum value for an employee's family members based on the value of the benefits provided to them. Together, these two reforms would ensure the availability of affordable marketplace plans for the family members of workers who have been offered employer-sponsored coverage for their families but for whom family coverage remains unaffordable.

¹ See *Proposed Rule, Affordability of Employer Coverage for Family Members of Employees*, 87 Fed. Reg. 20,354, 20,354 (Apr. 7, 2022).

We believe that this new regulatory approach to the problem of affordability is not simply the best reading of the ACA but, indeed, represents the *only* reasonable reading of the statute’s text, structure, history, and purpose. The text of the ACA makes clear that the ACA’s tax subsidies are barred for family members of employees only when employer-based coverage is affordable for both individual employees *and* their related family members. The proposed rule is not simply common-sense but rectifies the legal error contained in the agency’s existing regulations. For nearly a decade, countless families have been forced to forgo affordable insurance—or indeed, potentially any insurance at all—because of the agency’s error. The agency’s change is therefore not simply welcome—it is essential.

Below, we explain why the agency’s change is urgently needed. *See* Part I. We then explain why the agency’s current interpretation conflicts with the plain meaning of section 36B, and why section 36B mandates a family-based test. *See* Part II.

I. The Agency Must Correct the Family Glitch.

The family glitch undermines the ACA’s most fundamental goal: ensuring access to affordable, high-quality health coverage. The family glitch refers to the agency’s current interpretation of 26 U.S.C. § 36B, under which an employee’s family members cannot obtain the ACA’s tax subsidies if his or her employer has offered affordable self-only coverage, even if the employer’s offer of family coverage would exceed the ACA’s affordability threshold for the employee’s family as a whole.

Experts have estimated that anywhere from 4.8 million² and 5.1 million³ people are caught in the family glitch. The Congressional Budget Office has also estimated that more than 3 in 10 uninsured Americans— 9.1 million people—have access to subsidized employer coverage and that, within this group, approximately one-third have household incomes between 138 percent and 400 percent of the federal poverty level.⁴ For many workers within this group, the cost of coverage for the worker would not have exceeded 9.86 percent of income (the test of affordability in 2019), but the cost of *family* coverage would surpass this threshold, leaving them ineligible for subsidies. Indeed, under any calculation, millions of American families are ensnared by the agency’s current regulations.

Families facing this predicament are presented with two basic choices. They can either spend significantly more of their household incomes on insuring family members by purchasing full-priced policies through their employer (the predominant choice) or without subsidies on the individual market, or they can face the grim reality of leaving family members uncovered. Most of these families—approximately 90 percent—have chosen to purchase health insurance, but

² Matthew Buettgens & Jessica Banthin, *Changing the “Family Glitch” Would Make Health Coverage More Affordable for Many Families*, Urban Inst. 5 (May 11, 2021) <https://www.urban.org/research/publication/changing-family-glitch-would-make-health-coverage-more-affordable-many-families>.

³ Cynthia Cox et al., *The ACA Family Glitch and Affordability of Employer Coverage*, Kaiser Fam. Found. (Apr. 7, 2021), <https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage/>.

⁴ *Who Went Without Health Insurance in 2019, and Why?*, Congressional Budget Office 6 (Sept. 30, 2020), <https://www.cbo.gov/publication/56504>.

only at great cost to other basic needs such as housing, food, child care and education, employment expenses, and other costs essential to family well-being.⁵

Either way, the family's health suffers. The ability to access affordable health care is essential to health, particularly during the worst pandemic to affect the world in a century—one in which being unable to secure needed health care puts others at risk. Alternatively, the decision to sacrifice other vital economic supports in order to keep all family members insured triggers a cascade of other health risks, such as a lack of adequate housing, nutrition, or safe child care. The ACA was deliberately designed to guarantee that the overwhelming majority of American families no longer would have to face such choices.

The agency's proposed change would address this dilemma by allowing these families to be newly eligible for premium tax credits, enabling them to purchase affordable Marketplace coverage. The Urban Institute estimates that, under the agency's proposed correction, 710,000 more people would enroll in Marketplace plans, and slightly more than 90,000 family members (mostly children) would enroll in Medicaid or the Children's Health Insurance Program (CHIP).⁶ The number of uninsured Americans would experience a net decline of 190,000 people.⁷ Equally important, however, is that families switching from unaffordable employer plans to affordable marketplace plans would save \$400 per person in annual average premium costs, while families with incomes below 200 percent of the federal poverty level who make the switch would save a remarkable \$580 *per person* in premiums.⁸ Either way, for these families, the financial relief would be immense.⁹

Should the agency not reverse course and address the family glitch, this problem will continue to grow, as the cost of family coverage inexorably continues to increase.¹⁰ Premiums for a family of four surpassed \$22,200 on average by 2021, according to the Kaiser Family Foundation, and 12 percent of covered workers faced premium costs of at least \$10,000 that year.¹¹ The United States Labor Department reports that in 2021 the mean wage across all occupations was \$58,260,¹² making the average family plan equal to over 38 percent of family income. In the meantime, employer contributions to family coverage have steadily declined—if they ever existed

⁵ See Buettgens & Banthin, *supra* note 2, at 6.

⁶ *Id.* at 1.

⁷ *Id.*

⁸ *Id.*

⁹ The proposed change could also benefit the Marketplace risk pool more broadly: premiums in the individual market would decline by an estimated one percent, on average. These benefits would accrue even with a “negligible” impact on the employer market. See Buettgens & Banthin, *supra* note 2; Cox et al., *supra* note 3.

¹⁰ Gary Claxton et al., *Many Workers, Particularly at Small Firms, Face High Premiums to Enroll in Family Coverage, Leaving Many in the Family Glitch*, Kaiser Fam. Found. (Apr. 12, 2022) <https://www.kff.org/health-reform/issue-brief/many-workers-particularly-at-small-firms-face-high-premiums-to-enroll-in-family-coverage-leaving-many-in-the-family-glitch/>; see also Rachel Roubein, *Employer-Sponsored Coverage Keeps Getting More Expensive*, Wash. Post (Nov. 11, 2021), <https://www.washingtonpost.com/politics/2021/11/11/employer-sponsored-coverage-keeps-getting-more-expensive/> (“The cost of health insurance is—still—steadily rising for the nearly 155 million Americans who get health benefits through their job.”).

¹¹ Claxton et al., *supra* note 10.

¹² *May 2021 National Occupational Employment and Wage Estimates United States*, U.S. Bureau of Lab. Stats., https://www.bls.gov/oes/current/oes_nat.htm (last modified Mar. 31, 2022).

at all— especially for workers in industries where wages are lower, such as the service sector, and for smaller employers.¹³ Disproportionately represented in this group are workers and families of color, making a policy correction not only a legal imperative, but also a matter of fundamental health equity.

Addressing this ongoing legal error is a matter of urgency, since what is at stake is not merely the proper legal reading of the ACA, but also the alignment of the regulation with the ACA’s deeper meaning and purpose. The basic purpose of the Affordable Care Act was not to ensure near-universal coverage of virtually all Americans at any price. It was to ensure *affordable* coverage. Specifically, “the Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care.” *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012); *see also Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1315 (2020) (explaining that the Act seeks “to improve national health-insurance markets and extend coverage to millions of people without adequate (or any) health insurance”); *King v. Burwell*, 576 U.S. 473, 478-79 (2015) (The ACA aims “to expand coverage in the individual health insurance market.”).

Correcting the family glitch would serve to align the agency’s regulations with this objective. To be sure, the ACA preserves job-based coverage as the central means by which working-age Americans and their families obtain coverage. But the ACA also extends coverage through an expanded Medicaid program and the establishment of health insurance Marketplaces that offer good quality health plans at affordable prices by means of premium tax credits (and, in the case of lower-income people, cost-sharing assistance). Given the cost of employer-based family coverage in 2010—already a significant barrier to affordability—Congress could not have reasonably intended the ACA to exclude millions of people from access to any affordable coverage whatsoever.

II. The Family Glitch Violates the Affordable Care Act.

As the evidence above makes clear, there are ample policy and equity reasons to correct the so-called family glitch. But the agency should also do so for a more fundamental reason: the agency’s current regulations implementing section 36B badly misinterpret the statute. Properly understood, the statute *requires* that the affordability of family-based coverage be assessed based on how much an employee would need to contribute for such coverage. The fact that the agency has interpreted the statute otherwise for several years is no reason for it to continue doing so, and at substantial human cost. *Cf. Henslee v. Union Planters Nat. Bank & Tr. Co.*, 335 U.S. 595, 600 (1949) (Frankfurter, J., dissenting) (“Wisdom too often never comes, and so one ought not to reject it merely because it comes late.”).¹⁴

¹³ See Claxton et al., *supra* note 10.

¹⁴ These are not new arguments. When the agency proposed its current regulations, many commenters, including the American Federation of Labor and Congress of Industrial Organizations, the Center on Budget and Policy Priorities, the National Health Law Program, the National Women’s Law Center, and the Service Employees International Union, explained why the statutory language compelled a family-based test. See Internal Revenue Serv., *Health Insurance Premium Tax Credit*, Regulations.gov, <https://www.regulations.gov/document/IRS-2011-0024-0001> (last visited June 6, 2022). The agency’s failure to grapple with those arguments provides yet another reason for it to reconsider its existing regulations.

Below, we explain that (1) section 36B must be read to create a family-based test; (2) to ensure consistency, section 36B incorporates section 5000A's definition of required contribution, which the agency has correctly interpreted to create a family-based test; (3) if more were necessary, the ACA's other provisions concerning tax subsidies presuppose a family-based test; and (4) if even further evidence were required, such a test does not conflict with the ACA's inconclusive legislative history, and it supports its underlying purposes. For these reasons and others, the agency should be explicit in finalizing its proposal that the statutory language compels a family-based test.

A. Section 36B's affordability test requires the agency to consider whether family-based coverage is affordable.

To understand why the affordability of employer-sponsored coverage must be assessed based on the cost of covering related family members, one must look to the text, structure, and purpose of the Affordable Care Act. *See Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 320 (2014) (“[T]he words of a statute must be read in their context and with a view to their place in the overall statutory scheme.”) (quotation omitted).

The ACA “seeks to make insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line.” *King*, 576 U.S. at 482. The ACA therefore mandates that “there *shall* be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year,” 26 U.S.C. § 36B(a) (emphasis added); *see Nat'l R.R. Passenger Corp. v. Morgan*, 536 U.S. 101, 109 (2002) (“[T]he mandatory ‘shall[]’ ... normally creates an obligation impervious to judicial discretion.”). The amount of that credit is pegged to the second-lowest-cost silver plan on the Marketplace, colloquially referred to as the benchmark plan.

At the same time, the ACA prevents individuals who can otherwise access coverage from obtaining subsidies. Specifically, an individual cannot obtain subsidies for months in which they are “eligible for minimum essential coverage.” 26 U.S.C. § 36B(c)(2)(B). Minimum essential coverage encompasses government programs like Medicare, Medicaid, and CHIP, as well as multiple other forms of coverage. *See id.* § 5000A(f)(1).

One type of minimum essential coverage that can make an individual ineligible for tax credits is employer-sponsored coverage. *Id.* §§ 36B(c)(2)(B), 5000A(f)(1)(B). But, as explained above, employer-sponsored coverage can sometimes be too expensive, requiring a premium contribution that imposes an excessive burden on employees and effectively leaves them without an affordable insurance option.

The ACA therefore creates a “special rule for employer-sponsored minimum essential coverage.” 26 U.S.C. § 36B(c)(2)(C). As the subparagraph heading specifies, to preclude an employee from obtaining tax credits to purchase insurance on the market, such coverage “*must* be affordable”. *Id.* § 36B(c)(2)(C)(i) (emphasis added); *see Yates v. United States*, 574 U.S. 528, 540 (2015) (“[T]he title of a statute and the heading of a section are tools available for the resolution of a doubt about the meaning of a statute.”) (quoting *Almendarez-Torres v. United States*, 523 U.S. 224, 234 (1998)). For this reason, the Act allows employees to forgo their

employer-sponsored coverage in favor of a subsidy to purchase insurance on one of the ACA's exchanges if their "required contribution ... with respect to the plan" exceeds a certain percentage of the employee's household income.¹⁵ 26 U.S.C. § 36B(c)(2)(C)(i)(II). The statute further specifies that "[t]his clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee." *Id.*

Right off the bat, the text of section 36B suggests that coverage must be affordable both for the employee and for his or her family members. Under the statute, the "[s]pecial rule for employer-sponsored minimum essential coverage"—that such "[c]overage must be affordable"—applies equally "to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee." 26 U.S.C. § 36B(c)(2)(C). The affordability test therefore asks whether that related individual's "required contribution ... with respect to the plan" exceeds the affordability threshold. *Id.* That language can only mean the contribution that would be paid *for that individual's coverage*. Indeed, the statute also specifies that the correct inquiry looks to whether the "required contribution" for such coverage would exceed a certain percentage of their "*household income*." *Id.* § 36B(c)(2)(C)(i)(II) (emphasis added). It would be unusual to compare the entire household's income to the cost of obtaining coverage for the employee alone. And it is profoundly unfair to bar family members from obtaining tax subsidies even though their coverage is unaffordable.

That reading is also consistent with another provision of the Affordable Care Act that encourages employers to offer insurance to employees and their families. Under 26 U.S.C. § 4980H, large employers that fail to offer health coverage to "employees (*and their dependents*)" can be liable for financial penalties. *Id.* § 4980H(a) (emphasis added). Section 4980H therefore reinforces Congress's intent to ensure that family members also have access to affordable coverage options.¹⁶

Section 36B therefore mandates a family-based test. If Congress had intended a self-only test, it would have mandated that coverage be deemed affordable for a related family member so long as the employee can afford self-only coverage, rather than obliquely stating that the special rule applies to related family members as well. Instead, the only reasonable inference is that Congress intended to implement a test that assesses whether family-based coverage is affordable.

B. Section 36B's reference to section 5000A expressly incorporates a family-based affordability test.

Whether employer-based coverage is "affordable," moreover, is a question that recurs elsewhere in the statutory text—most notably in assessing whether an individual who refuses employer-based coverage is liable for the ACA's tax penalties, which are currently set at zero. Section 36B expressly cross-references that test, providing that employer-based coverage is deemed unaffordable if "the employee's required contribution (*within the meaning of [26 U.S.C. §] 5000A(e)(1)(B)*)" exceeds the applicable percentage of their household income. 26 U.S.C.

¹⁵ That percentage was 9.5 when the ACA was enacted and is adjusted annually.

¹⁶ An employer can also be held liable if they offer insurance, but that insurance is unaffordable or not of minimum value. *Id.* § 4980H(b). However, an employer can only be held liable if one of their employees also obtains a tax credit, *see id.* § 4980H(b)(1)(B)—meaning that the agency's proposal to permit related family members to obtain tax credits would not cause employers to face increased penalties.

§ 36B(c)(2)(C)(i)(II) (emphasis added). In doing so, Congress must have intended that sections 36B and 5000A be interpreted the same way.

Section 5000A, in turn, can only be read to impose a family-based test. Section 5000A also exempts “[i]ndividuals who cannot afford coverage”—again, those for whom the “required contribution” for such coverage would exceed a certain percent of their household income—from the ACA’s tax penalty. 26 U.S.C. § 5000A(e)(1)(A). For employees, the term “required contribution” means “the portion of the annual premium which would be paid by the individual ... for self-only coverage.” *Id.* § 5000A(e)(1)(B)(i). Once again, however, the ACA creates a “special rule[] for individuals related to employees”: that, “[f]or purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to [the] required contribution of the employee.” *Id.* § 5000A(e)(1)(C).

That rule makes good sense. A family member who obtains insurance through an employee is not required to directly “pay” anything for coverage; the *employee* makes the required contribution, usually through a reduction in their paycheck. The “special rule” therefore directs the agency to focus on the “required contribution of the employee” to determine whether the family member’s coverage is affordable. That phrase can only be read to refer to the “required contribution of the employee” *for the family member’s coverage*, because the entire point of the test is to assess whether family-based coverage is affordable. Otherwise, family members could face the ACA’s tax penalties even though they lacked access to an affordable coverage option.

Indeed, that is precisely the interpretation at which the agency arrived in interpreting section 5000A. It concluded that “the required contribution for a related individual’s coverage is determined by reference to the premium for the lowest cost coverage ... *in which the employee and all related individuals ... are eligible to enroll.*” *Proposed Rule, Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage*, 78 Fed. Reg. 7,314, 7,320 (Feb. 1, 2013) (emphasis added). In some cases, “[t]he required contribution for self-only coverage ... may cost less than 8 percent of household income, while the required contribution for family coverage ... may cost more than 8 percent of household income. In such a case, the employee is not exempt under section 5000A(e)(1), while the employee’s spouse and claimed dependents are exempt.” *Id.*; *see also* 26 C.F.R. § 1.5000A-3(e)(3)(ii)(B). That reading correctly recognized that family-based coverage is not “affordable” within the meaning of the statute when it costs an excessive percentage of a family’s household income.

Yet the agency reached a *different* conclusion in interpreting section 36B—one based on the agency’s failure to give weight to the special rule in section 5000A(e)(1)(C). According to the agency,

[t]he language of section 36B, through a cross-reference to section 5000A(e)(1)(B), specifies that the affordability test for related individuals is based on the cost of self-only coverage. By contrast, section 5000A, which establishes the shared responsibility payment applicable to individuals for failure to maintain minimum essential coverage, addresses affordability for employees in section 5000A(e)(1)(B) and, separately, for related individuals in section 5000A(e)(1)(C).

Final Rule, Health Insurance Premium Tax Credit, 78 Fed. Reg. 7,264, 7,265 (Feb. 1, 2013). In other words, the agency concluded that section 36B incorporates *only* the definition of required contribution from section 5000A(e)(1)(B), without the clarification included in subsection (e)(1)(C).

That approach fails to appreciate the relationship between subsections (e)(1)(B) and (e)(1)(C). Subsection (e)(1)(C) modifies the meaning of subsection (e)(1)(B) by creating a “special rule” “for purposes of” interpreting subsection (e)(1)(B) in cases involving related individuals. In that sense, subsection (e)(1)(C) operates as a proviso—a statutory element that acts to “except something from the enacting clause, or to qualify and restrain its generality and prevent misinterpretation.” *United States v. Morrow*, 266 U.S. 531, 534 (1925). Subsection (e)(1)(C) clarifies that, in applying subsection (e)(1)(B) to related individuals, the question is whether the required contribution for *their* coverage is affordable.

The fact that section 36B expressly references subsection (e)(1)(B), but not subsection (e)(1)(C), makes no difference. Statutory provisions often derive meaning from provisions found elsewhere in a statute. For example, the terms in a clause found buried in a complex statute may be defined at the beginning. *Cf. King*, 576 U.S. at 489 (“[E]very time the Act uses the word ‘Exchange,’ the definitional provision requires that we substitute the phrase ‘Exchange established under section 18031.’”) A reference to one section necessarily incorporates all of the provisions that might affect or change its meaning, particularly when one such provision is found in the very next section.

Equally important, “one ordinarily assumes ‘that identical words used in different parts of the same act are intended to have the same meaning.’” *Util. Air Regul. Grp.*, 573 U.S. at 319-20 (quoting *Env’t Def. v. Duke Energy Corp.*, 549 U.S. 561, 574 (2007)); *see also Ratzlaf v. United States*, 510 U.S. 135, 143 (1994) (“A term appearing in several places in a statutory text is generally read the same way each time it appears.”). And “[t]he provisions of a text should be interpreted in a way that renders them compatible, not contradictory.” *Maracich v. Spears*, 570 U.S. 48, 68 (2013) (quoting Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 180 (2012)). Simply by virtue of using the same term, one would naturally assume that Congress intended for the same approach to calculating the required contribution to apply, regardless of whether the issue is tax subsidies or tax penalties.

To be sure, “the presumption of consistent usage readily yields to context,” *Util. Air Regul. Grp.*, 573 U.S. at 320 (quotation omitted)—but the context here simply confirms the presumption. Both sections 36B and 5000A focus on the same question: whether employer-based coverage is “affordable.” And they share the same basic structure: a rule for employees alone, and then a special rule for related individuals. By expressly incorporating subsection (e)(1)(B), Congress sought to guarantee that the same affordability test would govern eligibility for the ACA’s tax subsidies and for its tax penalties. For the two provisions to then require two radically different methods of assessing whether family-based coverage is affordable cannot have been what Congress intended.

For these reasons, the statutory structure and basic canons of statutory construction both require the agency to apply the same family-based affordability test in both the tax subsidy and tax penalty contexts.

C. The ACA’s other tax credit-related provisions support a family-based test.

That conclusion is further bolstered by the fact that, in addition to sections 36B and 5000A, the parallel tax-credit provisions administered by the Department of Health and Human Services (“HHS”) necessarily presuppose a family-based coverage test. Both the IRS and HHS have important responsibilities in implementing the Affordable Care Act, and so the provisions that define those responsibilities should be interpreted harmoniously, even if different agencies are charged with implementing them. *See United Sav. Ass’n of Texas v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) (“Statutory construction ... is a holistic endeavor. A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme.”).

To wit, sections 36B and 5000A of Title 26 charge the IRS with *administering* the ACA’s tax credits and penalties, but it is 42 U.S.C. § 18081 that requires the Secretary of Health and Human Services to establish “[p]rocedures for determining *eligibility* for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.” (emphasis added). As part of those procedures, the Secretary must assess “whether an *individual’s* coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2) of Title 26.” 42 U.S.C. § 18081(a)(3) (emphasis added). Because section 18081 uses the term “individual” rather than “employee,” it indicates that both employees and related family members must have access to affordable coverage—not, as the agency’s self-only test would have it, whether the employee alone has access to affordable coverage.

Section 18081 also contains information-collecting responsibilities that would make little sense if sections 36B and 5000A imposed a self-only test. For example, if an employee or a related individual seeks a tax credit on the grounds that employer-based coverage is unaffordable, they must identify “the lowest cost option for the enrollee’s or individual’s enrollment status and the enrollee’s or individual’s required contribution (within the meaning of section 5000A(e)(1)(B) of Title 26) under the employer-sponsored plan.” *Id.* § 18081(b)(4)(C). In addition to indicating that the term “individual” is different from, and broader than, the term “employee,” the statute poses questions that would be unnecessary under a self-only test. If the affordability test focused solely on the cost of self-only coverage, the “lowest cost option” for related family members (*i.e.*, “individuals” other than the “enrollee”) is irrelevant. Similarly, if all that mattered was the employee’s required contribution for self-only coverage, there would be no reason to distinguish between the required contributions for enrollees *and* individuals. Only a family-based test makes sense of these requirements.

The fact that each of these provisions repeatedly references and incorporates the others provides further evidence that they were intended to be interpreted as part of a unified whole. But section 18081 contains yet another clue in that regard: it requires HHS to collect the same information for assessing affordability whether the question is the individual’s eligibility for tax subsidies or for an exemption from the ACA’s tax penalties. *See id.* § 18081(b)(5). In other words, Congress understood all of these provisions to entail the same family-based inquiry. That is how they must be interpreted.

D. A family-based test is consistent with the history and purpose of the ACA.

The ACA’s text and structure require a family-based affordability test. *Nat’l Ass’n of Mfrs. v. Dep’t of Def.*, 138 S. Ct. 617, 631 (2018) (“Because the plain language ... is unambiguous, our inquiry begins with the statutory text, and ends there as well.”) (quotation omitted). The ACA’s unclear and at times contradictory legislative history cannot change the meaning of its unambiguous statutory text—text that must also be read in line with the ACA’s fundamental purpose of guaranteeing affordable coverage. Indeed, as “[s]even Democratic lawmakers who played key roles in drafting and passing the law” emphasized while the agency was considering its current regulations, “[t]he notion that Congress wrote the law in a manner that would exclude many families from access to more affordable coverage ... is simply incongruent.”¹⁷

Before Congress passed the ACA, legislative bodies repeatedly described the affordability test as focusing on the cost of self-only or family-based coverage. In October 2009, the Senate Finance Committee issued a report analyzing the America’s Healthy Future Act, a precursor bill to the ACA sponsored by Senator Max Baucus (D-Montana), that contained materially similar language to sections 36B and 5000A. *Compare* America’s Healthy Future Act, S. 1796, 111th Cong. §§ 1205, 1301 (2009), *with* 26 U.S.C. §§ 36B, 5000A. That report noted that, under the bill, “[u]naffordable is defined as coverage with a premium required to be paid by the employee that is ten percent or more of the employee’s income, based on the type of coverage applicable (*e.g., individual or family coverage*).”¹⁸ Legislators therefore understood the affordability requirement to include a family-based test as they were debating the ACA.

That same conclusion was echoed by a report issued by the Joint Committee on Taxation Report just days before the ACA was enacted. In that report, the Committee reiterated that “[u]naffordable is defined as coverage with a premium required to be paid by the employee that is 9.5 percent or more of the employee’s household income, based on the type of coverage applicable (*e.g., individual or family coverage*).” Staff of the Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the “Reconciliation [sic] Act of 2010,” As Amended, in Combination with the “Patient Protection and Affordable Care Act,”* JCX-18-10, at 15 (March 21, 2010) (emphasis added).

However, the report also contains a footnote contradicting that view. In describing the ACA’s tax penalties, the Committee addressed a hypothetical employee offered self-only coverage costing five percent of their income and family-based coverage for ten percent. The Committee explained that, “[a]lthough family coverage costs more than 9.5 percent of income, the family does not qualify for a tax credit regardless of whether the employee purchases self-only coverage or does not purchase self-only coverage through the employer.” *Id.* at 33 n.70. Over a month later, and after the ACA was enacted, the Committee issued errata for the report appearing to side with the footnote and directing that “the type of coverage applicable (*e.g.,*

¹⁷ Julie Appleby, *Advocates Fear Tax-Credit Rule Will Exclude Some From Health-Care Benefit*, Wash. Post (Apr. 15, 2012), https://www.washingtonpost.com/politics/advocates-fear-tax-credit-rule-will-exclude-some-from-health-care-benefit/2012/04/15/gIQAJuW6JT_story.html (describing a letter sent by the lawmakers to the agency).

¹⁸ *America’s Healthy Future Act of 2009*, S. Rep. 111-89, at 39 (2009), <https://www.finance.senate.gov/imo/media/doc/prb102109a3.pdf>.

individual or family coverage)’ should be replaced with ‘self-only coverage’” on page 15. Staff of the Joint Committee on Taxation, *Errata for JCX-18-10*, JCX 27-10 (May 4, 2010). However, “the JCT’s narrow point of view wasn’t apparent at the time that PPACA was being voted upon, because on the day the final vote took place in the House, the JCT told Congress something different.”¹⁹

Neither the footnote nor the errata should detract from the plain meaning of the ACA’s text. The Senate Finance Committee and Joint Committee on Taxation reports, issued six months apart, suggest that section 36B was understood to impose a family-based test during the time it was being crafted and debated. And the errata constitute “[p]ost-enactment legislative history (a contradiction in terms),” which “is not a legitimate tool of statutory interpretation.” *Bruesewitz v. Wyeth LLC*, 562 U.S. 223, 242 (2011).²⁰ At most, these dueling assertions about the meaning of section 36B would incline a reviewing court to give little weight to the legislative history.

Nor would a court give significant weight to the various bills that have been introduced to provide a legislative “fix” to the family glitch. Some have suggested that the failure of these bills reflect Congress’s acceptance of the agency’s current regulations. In addition to constituting “post-enactment legislative history,” *id.*, however, “failed legislative proposals are a particularly dangerous ground on which to rest an interpretation of a prior statute,” *Cent. Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 187 (1994) (quotation omitted). “Congressional inaction lacks persuasive significance because several equally tenable inferences may be drawn from such inaction, including the inference that the existing legislation already incorporated the offered change.” *Id.* Moreover, at least one of those bills emphasized Congress’s sense that the agency has the authority to address the family glitch without additional legislative action.²¹

To the extent there is any ambiguity remaining in the relevant statutory provisions, it must instead be resolved by recourse to the ACA’s most fundamental purpose. “Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them,” and “we must interpret the Act in a way that is consistent with the former, and avoids the latter.” *King*, 576 U.S. at 498. As explained above, the *Affordable Care Act* was intended to guarantee *affordable* coverage. To that end, the ACA seeks to maintain an employer-based coverage system while guaranteeing that individuals—be they employees or family members—who cannot obtain affordable coverage through an employer have another route to obtaining coverage. Rather than suggesting that the ACA counterintuitively permits the agency to erect an

¹⁹ Avik Roy, *Obamacare Bombshell: 4 Million People Who Thought They Were Gaining Coverage, Won’t*, *Forbes* (Aug. 10, 2011), <https://www.forbes.com/sites/theapothecary/2011/08/10/obamacare-bombshell-did-the-government-underestimate-the-costs-of-ppacas-exchanges-by-hundreds-of-billions/?sh=1c08fd1623b1>.

²⁰ The same is true of a 2011 report adopting the same interpretation. See Staff of the Joint Committee on Taxation, *General Explanation of Tax Legislation Enacted in the 111th Congress*, JCS-2-11, at 265 (March 16, 2011).

²¹ See Family Coverage Act, S. 2434, 113th Cong. (2014), <https://www.govtrack.us/congress/bills/113/s2434> (expressing the “sense of Congress” that the agency has “the administrative authority necessary to apply the affordability provision in section 36B of the Internal Revenue Code . . . to expand access to affordable health insurance coverage for working families without further legislation”).

artificial barrier to affordable coverage, the agency should make plain that the only reasonable reading of the statute entails a family-based affordability test.

* * *

To be clear, we agree with the policy arguments that support the agency's change, and believe that the agency's proposal should withstand legal challenge. Given the importance of correcting this error, however, we would also encourage the agency to rely on the statutory text. Specifically, the agency should explain both why the proposed rule rests on the "unambiguously expressed intent of Congress," and expressly find, in the alternative, that it represents "a permissible construction of the statute," as the agency suggests it is inclined to do in its proposal. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984). "Where ... an agency has set out multiple independent grounds for a decision," a court "will affirm the agency so long as *any one* of the grounds is valid, unless it is demonstrated that the agency would not have acted on that basis if the alternative grounds were unavailable." *Fogo De Chao (Holdings) Inc. v. DHS*, 769 F.3d 1127, 1149 (D.C. Cir. 2014) (emphasis added) (quotation omitted). The agency's new interpretation is both good policy and the correct interpretation of the law, and it should not hesitate to say so.

In any event, the agency's current regulations misinterpret the ACA to the detriment of families nationwide. We therefore encourage the agency to finalize its proposed rule, and in doing so, explain why that rule is supported by policy considerations and also represents the correct interpretation of the statutory text. If you have any questions or would like to discuss the information contained in this comment, please contact John Lewis at the Democracy Forward Foundation at jlewis@democracyforward.org.

APPENDIX A – INDIVIDUAL COMMENTERS

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