AMERICAN EXPERIMENT

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June 6, 2022

The Honorable Janet L. Yellen
Secretary of the Treasury
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, D.C. 20220

The Honorable Charles P. Rettig
Commissioner
Internal Revenue Service
1111 Constitution Avenue NW
Washington, D.C. 20224

Submitted via www.federalregister.gov

RE: [REG-114339-21] Affordability of Employer Coverage for Family Members of Employees

Dear Secretary Yellen and Commissioner Rettig:

Thank you for the opportunity to provide comments on the proposals included in the notice of proposed rulemaking "Affordability of Employer Coverage for Family Members of Employees." As a state-based public policy organization in Minnesota, Center of the American Experiment focuses on creating and advocating policies that make Minnesota a freer, more prosperous and better-governed state. Beyond state government policies, this includes a strong interest in how federal policies impact the people of Minnesota. Federal agencies must always take care to ensure their regulatory actions operate within the constitutional and statutory limits that govern their authority. No matter how well-intended, any agency action that colors outside these established limits violates the public trust and severely undermines the legitimacy of the agency.

Unfortunately, the policies included in this proposed rule color well outside the statutory authorities that govern the Department of the Treasury and the Internal Revenue Service (hereinafter the Agencies). The plain language of the statutory text unambiguously includes the family glitch as part of the process to determine premium subsidy eligibility for individuals with access to employer coverage through a relationship with an employee. The legislative history confirms this plain reading and shows how Senate amendments narrowed premium subsidy eligibility standards for these related individuals to create the family glitch. Furthermore, this narrower eligibility standard served several important purposes that helped Congress negotiate the competing mix of priorities necessary to enact the ACA. Adding the family glitch lowered the ACA's cost, reduced the incentive for employers to drop coverage, and protected the individual market risk pool.

The family glitch may negatively impact some Americans, but Congress clearly enacted it by design after weighing competing priorities. Therefore, fixing it administratively would illegally sidestep Congress and undermine the legitimacy of the Agencies. We strongly urge the Agencies to not finalize the proposed rule and, instead, exercise the restraint necessary to keep the public trust.

I. Family glitch bases affordability on the cost of self-only coverage, not family coverage

To help make individual market health insurance premiums more affordable, the ACA provides premium tax credit subsidies to people with incomes between 100 and 400 percent of the federal poverty level. However, people generally do not qualify for premium subsidies if they are eligible for other coverage, referred to as minimum essential coverage (MEC), by the government or an employer.[1] Therefore, people generally do not qualify for premium subsidies if they are offered coverage by their employer or a related individual's employer. This is referred to as the "firewall" between employer coverage and subsidized coverage. Absent this firewall, the Congressional Budget Office (CBO) estimates that about a quarter of the 151 million people with employer coverage would qualify for premium subsidies.[2]

There are two exceptions to the firewall. Employees can still qualify for premium subsidies if the coverage offered by their employer is not "affordable" or does not provide "minimum value." To be affordable, the employee's share of the premium for "self-only coverage" must not exceed 9.5 percent of household income, which is referred to as the "required contribution percentage."[3] To meet the minimum value requirement, employer coverage must cover at least 60 percent of the total allowed costs of the benefits provided by the plan.[4] In other words, the plan must be generous enough to cover 60 percent of the expected average cost of the covered benefits to the employee.

The family glitch arises because the law bases the affordability exception for the entire family on the employee's share of premium for "self-only coverage," not family coverage. Therefore, the firewall restricts both the employee *and* their dependents from premium subsidies when the premium for self-only coverage exceeds 9.5 percent of household income. The Kaiser Family Foundation estimates 5.1 million people are impacted by the family glitch.[5] That represents a

[1] 26 USC 36B(c)(2)(B). Minimum essential coverage generally includes coverage under Medicare, Medicaid, the Children's Health Insurance Program, TRICARE, certain plans under the Veterans Administration, the Peace Corp, the Nonappropriated Fund Health Benefits Program through the Department of Defense, employer-sponsored plans, individual market plans, and grandfathered plans. 26 USC 5000A(f)(1).
[2] Congressional Budget Office, *Answers to Questions for the Record Following a Hearing Conducted by the Senate Committee on the Budget on CBO's Budget Projections*, December 18, 2020, available at https://www.cbo.gov/publication/56908.
[3] 26 USC (c)(2)(C)(i). The required contribution percentage is annually indexed to reflect the rate of premium growth in excess of the rate of income growth from the previous year. In 2022, the required contribution percentage is set at 9.61 percent.
[4] 26 USC (c)(2)(C)(ii).
[5] Cynthia Cox, et al., *The ACA Family Glitch and Affordability of Employer Coverage*, Kaiser Family Foundation, April 7, 2021, available at https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage/.

substantial portion—around 14 percent—of the people who the CBO estimates would qualify for subsidies without the firewall.

II. The Agencies prior rulemaking concludes the statute ties affordability to the cost of self-only coverage

The Agencies issued proposed regulations in August 2011 that concluded "the statutory language specifies that for both employees and others (such as spouses or dependents) … coverage is unaffordable if the required contribution for 'self-only' coverage (as opposed to family coverage or other coverage applicable to multiple individuals) exceeds 9.5 percent of household income."[6] For support, the proposal cited to a March 2011 explanation of tax legislation enacted by the 111th Congress published by the Joint Committee on Taxation (JCT).[7]

The Agencies did not finalize this proposal when they finalized other aspects of this rule in 2012.[8] Instead, they acknowledged that some commenters suggested that affordability for related individuals should be based on the cost of the family premium and deferred addressing the issue to future rulemaking without addressing the comments.

The Agencies eventually finalized the rule as proposed without change in February 2013.[9] In response to comments suggesting affordability should be based on premiums for family coverage, the final rule explained how the statutory language does not support this view.[10] Specifically, the rule noted how a cross reference in section 36B of the tax code to section 5000A(e)(1)(B)—a section which governs the individual mandate exemption—specifies that the affordability test for both employees and related individuals is based on self-only coverage.[11]

Importantly, the rule went further and explained how the statutory text addresses affordability differently for the purposes of premium subsidy eligibility versus the individual mandate exemption. In contrast to section 36B's direct cross reference to section 5000A(e)(1)(B), the rule notes how section 5000A(e)(1)(C) treats affordability "separately" for related individuals for the purposes of the individual mandate penalty exemption. In this case, affordability is based on the cost of the family premium.[12] In this final rule, the Agencies never hinted to any ambiguity in the statute. Nor did the Agencies suggest their conclusions were steered by policy preferences or regulatory discretion. Instead, the Agencies appeared to be resting on a rather straightforward statutory construction analysis.

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[6] 76 FR 50931.
[7] Id. at 50935 *citing* Joint Committee on Taxation, *General Explanation of Tax Legislation in the 111th Congress*, JCS-2-11 (March 2011), at 265, available at https://www.jct.gov/publications/2011/jcs-2-11/ ("Unaffordable is defined as coverage with a premium required to be paid by the employee that is more than 9.5 percent of the employee's household income, based on the self-only coverage.").
[8] 77 FR 30377, at 30380.
[9] 77 FR 7264.
[10] Id. at 7265.
[11] Id.
[12] Id. This final rule on premium subsidy eligibility cites to a proposed rule issued concurrently which separately bases the required contribution on the cost of family coverage for the purposes of the individual mandate penalty exemptions. *See* 78 FR 7314, at 20.

III. The proposed rule argues there is now a "better reading" of the statute

In the proposed rule to fix the family glitch, the Agencies acknowledge their previous conclusion that "the *language* of section 36B, through the 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" (emphasis added).[13] Thus, the proposal acknowledges the statute directed this outcome. Moreover, in response to comments that opposed this outcome, the proposal acknowledges how the Agencies previously reserved finalizing the rule in 2012 "[t]o fully consider those comments and ensure a comprehensive analysis of the issue."[14] Thus, the proposal acknowledges this outcome was not rushed or taken lightly. Nonetheless, the Agencies lament how this outcome "has potentially impacted millions of Americans" and "undermined access to more affordable health care coverage by preventing access to lower-premium subsidized Exchange plans."[15] Therefore, pursuant to Executive Order 14009, the proposed rule reexamines the current interpretation of section 36B.

After reexamining the statute, the Agencies have "tentatively determined" that "the statute is better read to require a separate affordability determination for employees and for family members."[16] The Agencies further conclude that the current interpretation "unduly weakens the ACA" and is, therefore, "contrary to the policy of the ACA to expand access to affordable health care coverage."[17] This interpretation of the statute relies on the following argument.

- "Flush language" (i.e., language in the tax code with no letter or number next to it) in IRS Code section 36B that applies the affordability test to related individuals creates ambiguity because it does not specify how to understand the cross-reference to self-only coverage in section 5000A(e)(1)(B) with regards to related individuals.
- Ambiguity in the statute is further demonstrated by the fact that the initial explanation of the ACA published by the JCT in March 2010 tied the affordability test in section 36B to family coverage, which was later corrected to self-only coverage in an errata.
- This statutory ambiguity is best addressed by incorporating how the special rule for determining affordability for related individuals in section 5000A(e)(1)(C) modifies section 5000A(e)(1)(B)(i) for the purposes of the individual mandate penalty exemption under section 5000A(e)(1) in the same manner for related individuals for the purposes of determining premium subsidy eligibility under section 36B.
- This interpretation would tie the affordability test for related individuals to the cost of family coverage for both section 36B and section 5000A, which would create consistency across parallel statutory provisions.
- The interpretation would also rationalize the information reporting requirements for applicants regarding employer-sponsored coverage in 42 U.S.C. 18081(b)(4)(C). This statutory provision requires premium contribution information for related individuals when only the employee contribution matters for determining affordability under the current interpretation.

[13] 87 FR 20354, at 20356.
[14] Id.
[15] Id.
[16] Id. at 20355 and 20356.
[17] Id. at 20356.

- The amended interpretation would support the intent of the drafters of the ACA to expand access to affordable health coverage.

These arguments largely mirror a legal analysis Katie Keith briefly outlined in a *Health Affairs Forefront* article on fixing the family glitch last year.[18] While the Agencies maintain this reexamination offers "the better reading" of the statute, the thread connecting each of these arguments begins to quickly unravel upon a closer examination of the statute and other supporting sources.[19]

IV. Statute clearly sets affordability for related individuals to the cost of self-only coverage

The Agencies' initial argument begins by attempting to introduce ambiguity into the statute where it had previously found none. This is necessary to justify the reexamination and introduce an alternative reading.[20] However, the statute provides a very clear, unambiguous test for whether employer-sponsored coverage is affordable to related individuals for the purpose of determining eligibility for premium subsidies under section 36B.

According to section 36B(c)(2)(C)(i)(II), an employee's coverage is not affordable when "the employee's required contribution (*within the meaning of section 5000A(e)(1)(B)*) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income" (emphasis added). This is followed by flush language stating: "This 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." The Agencies claim this flush language creates ambiguity because it does not specify *how* the prior clause should apply to related individuals or *how* to understand the cross-reference to section 5000A(e)(1)(B).

While it is true the flush language cited by the Agencies does not itself specify *how* the law's affordability test should be applied to related individuals, the preceding sentence *does* explain this key point by specifically cross-referencing section 5000(A)(e)(1)(B). This cross-referenced text then specifically states that the "required contribution" for someone eligible to purchase employer coverage is "the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for *self-only coverage*" (emphasis added). There is no ambiguity here. The cross-referenced language specifically bases the affordability test on self-only coverage and the flush language specifically applies this same test to related individuals.

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[18] Katie Keith, "Fixing the ACA's Family Glitch," *Health Affairs Forefront*, May 20, 2021, available at https://www.healthaffairs.org/do/10.1377/forefront.20210520.564880/.

[19] 87 FR 20354, at 20357.

[20] In discussing the prior rulemaking in the proposed rule, the Agencies suggest that they previously considered two readings. However, it's important to reiterate that the Agencies never acknowledged any ambiguity in the statute prior to this proposed rule. The current interpretation was finalized in 2013 with a brief, matter-of-fact description of the statutory text. As the Agencies admit in their proposal, this was the culmination of a delayed decision to ensure a full consideration. Generally, federal agencies acknowledge when commenters make plausible legal arguments and use the preamble text to explain why the law better supports their final determination. In this case, the Agencies never acknowledged any specific legal arguments from the comments, which strongly suggests they were of the view that the statute spoke clearly enough for itself.

The Agencies' reexamined interpretation hinges on using the special rule for related individuals in section 5000A(e)(1)(C) to modify the meaning of section 5000(A)(e)(1)(B) for the purposes of determining eligibility for premium tax credits. In making this argument, the Agencies fail to acknowledge the full text of section 5000A(e)(1)(C) and how it applies the special rule specifically to the individual mandate exemption "determination under subparagraph [5000A(e)(1)](A)." Based on a plain reading of the statute, the sole purpose of section 5000(A)(e)(1)(C) is to establish that affordability exemptions from the individual mandate penalty for people who are eligible for employer coverage by reason of a relationship to the employee must be based on the cost of employer coverage, not individual market coverage. Without this provision, dependent individuals would be able to choose between two affordability metrics to qualify for an exemption.

Importantly, including a specific reference to section 5000(A)(e)(1)(A) shows Congress intended to apply section 5000A(e)(1)(C) exclusively to setting the individual mandate exemption determination. By the well-established negative-implication canon of statutory interpretation, this specific reference excludes the use of the special rule for other purposes, including premium subsidy eligibility determinations under section 36B. Put simply, the inclusion of section 5000A(e)(1)(A) in section 5000A(e)(1)(C) excludes applying it for the purposes of section 36B.

In sum, the direct cross-reference from section 36B(c)(2)(C)(i)(II) to section 5000A(e)(1)(B) unambiguously specifies affordability for employees and related individuals is based on the cost of self-only coverage for the employee. Moreover, the exclusive reference in section 5000A(e)(1)(C) to the affordability test for the individual mandate exemption in section 5000A(e)(1)(A) reinforces how the cross-reference cannot be read to incorporate section 5000A(e)(1)(C) into the separate affordability test for premium subsidies under section 36B.

V. JCT error was due to a drafting mistake, not ambiguity

Though the text of the statute appears clear, the Agencies cite to an error in a JCT report which they argue demonstrates the statute's ambiguity. The JCT is a nonpartisan committee of the U.S. Congress that is responsible for estimating the budgetary effects of tax changes in proposed legislation.[21] If JCT were truly confused, then their error could suggest ambiguity. However, the legislative history shows this error was a simple drafting mistake tied to earlier versions of the legislation, not from confusion over how to interpret the legislation as enacted.

On March 21, 2010, the same day the ACA passed in the U.S. House, the JCT issued a report on the legislation which stated affordability is "based on the type of coverage applicable (e.g., individual or family Coverage)."[22] Then, on May 4, 2010, JCT issued an errata correcting this language which replaced "the type of coverage applicable (e.g., individual or family coverage)"

[21] Congressional Budget Office, *How CBO and JCT Analyze Major Proposals That Would Affect Health Insurance Coverage*, February 22, 2018, available at https://www.cbo.gov/publication/53571.
[22] Joint committee on Taxation, *Technical Explanation Of The Revenue Provisions Of The "Reconciliation Act Of 2010," As Amended, In Combination With The "Patient Protection And Affordable Care Act"*, JCX-18-10 (March 21, 2010), available at https://www.jct.gov/publications/2010/jcx-18-10/.

with "self-only coverage."[23] JCT's determination that affordability was based on self-only coverage was clearly stated here.

Internal inconsistencies in this JCT report and a comparison to language in a prior Senate Finance Committee report suggest the error surfaced from a simple cut-and-paste drafting error, not confusion over the statute. The error occurred on page 15 of the report while footnote 70 on page 33 clearly explained that "[a]lthough family coverage costs more than 9.5 percent of income, the family does not qualify for a tax credit." Moreover, the footnote contrasts how affordability for the individual mandate exemption is based on the cost of family coverage. This clear description, in full agreement with the errata, shows the JCT did not suddenly change their interpretation after a closer look at the legislation and then issue the errata.

The Agencies' proposed rule failed to note this internal inconsistency. This failure contributed to their flawed conclusion that the error reflected "differing interpretations by the Joint Committee staff." If they had thoroughly read JCT's full report, they likely would not have drawn this conclusion. It's hard to believe JCT staff held differing interpretations at the same time they drafted the report. Instead, the obvious explanation for this internal inconsistency is a simple drafting error.

But how might such a drafting error surface? It turns out congressional staff with the Senate Finance Committee used nearly identical language as the erroneous JCT language in a report published on October 19, 2009 describing S. 1796, the America's Healthy Future Act of 2009.[24] This was one of two Senate bills that were later consolidated and amended to create the ACA which the Senate passed on December 24, 2009.[25] This earlier version of the ACA did not include the statutory text that ultimately established the family glitch. Thus, the Senate report correctly described this version of the legislation. This leads to the obvious explanation that JCT introduced the error by mistakenly cutting and pasting a description of this earlier version without updating it. Therefore, this does not reflect any confusion and ambiguity over what the statute says on the part of the JCT.

VI. Legislative history shows the family glitch was enacted by design

The JCT error and its relationship to descriptions of S. 1796 reveals the legislative history that shows how the Senate amended S. 1796 to add the family glitch to the ACA by design, not by accident.

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[23] Joint committee on Taxation, *Errata for JCX-18-10*, JCX-27-10 (May 4, 2010), available at https://www.jct.gov/publications/2010/jcx-27-10/.

[24] Committee on Finance, United States Senate, *America's Healthy Future Act: Report (to accompany S. 1796) on Providing Affordable, Quality Health Care for All Americans and Reducing the Growth in health Care Spending, and for other Purposes together with Additional and Minority Views*, Report 111-89 (October 19, 2019), available at https://www.finance.senate.gov/imo/media/doc/prb102109a3.pdf. The only difference in language is that the Senate report does not use the term "household" when describing income and it uses ten percent of income versus 9.5 percent when describing the affordability threshold. The Senate report uses ten percent because that is the percent S. 1796 included as introduced.

[25] Congressional Research Service, *Health Reform and the 111th Congress* (February 25, 2010), available at https://www.everycrsreport.com/files/20100225_R40581_53375fa2d352cbc230a8089ce213c427623bd291.pdf.

As introduced, S. 1796 based the required contribution on the cost of health coverage generally and not the cost of self-only coverage.[26] Thus, the affordability test for an employee was based on "the type of coverage applicable (e.g., individual or family coverage)."[27] In addition, S. 1796 plainly included a cross reference from section 36B on determining premium subsidy eligibility to the entire section on "Exemptions" in section 5000A. As such, this cross reference incorporated both the definition of "required contribution" and the "special rule" applying the required contribution determination to related individuals. Under this framework, the affordability test for determining premium subsidy eligibility and individual mandate exemptions would be the same and affordability for related individuals would be based on the cost of family coverage. Consequently, there was no family glitch under this version of the legislation.

Amendments to S. 1796 changed this framework in three important ways which, together, created a separate affordability test for determining premium subsidy eligibility for related individuals.

- First, the Senate amended the definition of required contribution in section 5000A(e)(1)(B)(i) to mean the portion of premium paid for "self-only coverage."
- Second, the Senate amended the cross-reference in section 36B to specifically target section 5000A(e)(1)(B) and its new reference to self-only coverage. The cross-reference in the previous version pointed more broadly to the whole section on "Exemptions" that incorporated both the required contribution definition and the "special rule" for related individuals. By narrowing the cross reference, the amendment removed this incorporation of the special rule on related individuals.
- Third, the Senate amended section 5000A(e)(1)(C) to specify that the special rule for related individuals applies only to the individual mandate exemption determination.

The coordination between these three changes demonstrates how the Senate established the family glitch by design. In section 5000A(e)(1)(B), the required contribution definition was amended to mean the portion of premium paid for self-only coverage, not health coverage generally. Then the cross reference in section 36B narrowed to exclusively reference this amended definition in section 5000A(e)(1)(B). This worked to exclude the special rule for related individuals located in section 5000A(e)(1)(C) from the cross reference. Alone, these two changes read to say the special rule no longer applies to the section 36B affordability test.

Notably, the third change was not included in the first version of the ACA introduced on November 19, 2009.[28] In what appears an effort to remove any ambiguity, the Manager's Amendment proposed on December 19, 2009 added section 10106(d) to the ACA which

[26] America's Healthy Future Act of 2009, S. 1796, 111th Cong. §§ 1205 and 1301 (introduced October 19, 2009).
[27] Committee on Finance, United States Senate, *America's Healthy Future Act: Report (to accompany S. 1796) on Providing Affordable, Quality Health Care for All Americans and Reducing the Growth in health Care Spending, and for other Purposes together with Additional and Minority Views*, Report 111-89 (October 19, 2019), available at https://www.finance.senate.gov/imo/media/doc/prb102109a3.pdf.
[28] Amdt. No. 2786, H.R. 3590, 111th Congress § 1401 (2009) https://www.congress.gov/bill/111th-congress/house-bill/3590/text/as.

amended section 5000A(e)(1)(C) to specify that the special rule for related individuals applies to "determinations under [section 5000A(e)(1)](A)."[29]

Ultimately, the way these three changes fit together shows the Senate clearly intended to base the affordability test for related individuals on the cost of self-only coverage, but only for the purpose of determining eligibility for premium subsidies. Importantly, the Agencies' proposed interpretation reflects exactly how the ACA would have worked under S. 1796 without these amendments. Logically then, to adopt this interpretation, the Agencies must also adopt the position that the amendments changed nothing, which is an untenable position.

VII. Congress intended the inconsistency between affordability determinations for premium subsidy eligibility and individual mandate exemptions

The Agencies assert the current interpretation adopts inconsistent interpretations of affordability for the purposes of subsidy eligibility versus individual mandate exemptions. The Agencies note the proposed "interpretation would create consistency across parallel provisions of the Code enacted by the ACA" without explaining why that is even an appropriate goal.[30] Yet, as previously outlined, the amendments incorporated into the ACA show Congress clearly intended to establish this inconsistent approach. There is no conflict with the statute because the statute clearly applies the special rule to only individual mandate exemptions. Furthermore, it is entirely reasonable for Congress to create this inconsistency. It certainly makes sense for Congress to make it easier for a family to qualify for an exemption from the harm imposed by a costly penalty than to qualify for a premium subsidy benefits at taxpayers expense.

VIII. No inconsistency with other ACA provisions

The Agencies also argue the proposed interpretation would "promote consistency between the affordability rules in these provisions and 42 U.S.C. 18081(b)(4)(C), which requires Exchange applicants to separately provide the required contributions of employees *and* of related individuals in order to determine PTC eligibility; in the Agencies' view, the requirement to provide this information would make little sense if PTC eligibility depended only on the cost to the employee for self-only coverage" (emphasis added).[31]

This argument rests on a mistaken reading of the statutory text. The Agencies have erroneously substituted "and" where the statute says "or." The statute requires enrollees to provide information on "the lowest cost option for the enrollee's *or* individual's enrollment status and the enrollee's *or* individual's required contribution" (emphasis added).[32] By using the term "or" versus "and," the statute is clearly requiring information on the required contribution for only the individual employee who is offered employer coverage. The text is drafted in this manner to account for the fact that the individual employee that would pay the required contribution can be either the applicant enrolling (i.e., the enrollee) or someone related to the applicant (e.g., the

[29] 155 Congressional Record S13490, at S13497, December 19, 2009, available at https://www.congress.gov/congressional-record/2009/12/19/senate-section/article/S13490-2
[30] 87 FR 20354, at 20356.
[31] 87 FR 20354, at 20357.
[32] 42 U.S.C. 18081(b)(4)(C).

applicant's parent or spouse). In either case, the only information required by the statute is the lowest cost option for self-only coverage and the required contribution for the applicable employee, whether they are the enrollee or related to the enrollee.

This reading is supported by how the statute explains an enrollee must provide this information when eligibility for premium subsidies is "being established on the basis that the enrollee's (or related individual's) employer" does not provide affordable coverage.[33] The statute also asks for information on "[w]hether the enrollee or individual is a full-time employee."[34] This language reflects the fact that the applicant may either be the employee or related to the employee whose access to employer coverage will determine their subsidy eligibility. This fits squarely with the affordability test for determining premium subsidy eligibility.

IX. ACA serves multiple, competing purposes

To round out their rationale, the Agencies argue "the proposed amendment would also support efforts to achieve the goal of the ACA to provide affordable, quality health care for all Americans."[35] This is certainly true, but it ignores all the other competing goals and priorities that shaped the ACA. As Justice Scalia noted in his dissenting opinion in *King v. Burwell*, the case regarding the availability of the ACA's tax credits through HealthCare.gov, "[n]o law pursues just one purpose at all costs, and no statutory scheme encompasses just one element."[36] Alongside the goal to expand affordable coverage, the ACA pursued several complementary and competing congressional goals which the family glitch helped support. In particular, the family glitch lowered the law's impact on the federal budget deficit, reduced the incentive for employers to drop coverage, and protected the individual market risk pool.

A. Adding the family glitch lowers the federal budget deficit

Congress and President Obama enacted the ACA to help control deficits. In his health care speech to the joint session of Congress in September 2009, President Obama asserted "our health care problem is our deficit problem" and promised that he would "not sign a plan that adds one dime to our deficits."[37] In 2011, the Obama administration referred to the deficit reduction achieved through the ACA as "historic."[38] Including the family glitch helped shave the cost of Exchange subsidies, which mitigated the subsidies' deficit impact. Changes between CBO's initial estimates of the Senate Finance Committee version in September 2009[39] and the introduction of the ACA in November 2009[40] suggest this change reduced the number of people

[33] 42 U.S.C. 18081(b)(4)
[34] 42 U.S.C. 18081(b)(4)(B)
[35] 87 FR 20354, at 20357.
[36] King v. Burwell, 576 U.S. 473 (2015) (Scalia dissenting).
[37] Remarks by the President to a Joint Session of Congress on Health Care, September 9, 2009, available at https://obamawhitehouse.archives.gov/the-press-office/remarks-president-a-joint-session-congress-health-care.
[38] Office of the Press Secretary, The White House, "FACT SHEET: The President's Framework for Shared Prosperity and Shared Fiscal Responsibility," April 13, 2011.
[39] Congressional Budget Office, *Supplemental Information on Potential Effects of the Affordable Health Choices Act* (September 10, 2009), available at https://www.cbo.gov/publication/41247.
[40] Congressional Budget Office, *Patient Protection and Affordable Care Act* (November 18, 2009), available at https://www.cbo.gov/publication/41423.

qualifying for subsidies by as much 1 million. Based on CBO's estimate that the average Exchange subsidy per enrollee would cost $5,500, the change saved up to $5.5 billion in 2019. That's a substantial savings relative to the total $106 billion the CBO projected the Exchange subsidies would cost for that year.[41] This level of savings is consistent with the CBO's estimate from 2020 on how much it would cost to fix the family glitch.[42]

B. Adding the family glitch secures and stabilizes existing health coverage

In his speech to the joint session of Congress, Obama also emphasized the ACA's goal to "provide more security and stability to those who have health insurance."[43] Obama expressed this goal most memorably in his famous promise: "If you like your health care plan, you can keep your health plan."[44] While that turned out to be false,[45] it is true that the ACA is structured to avoid displacing the coverage people already have and like. In particular, the law aimed to ensure people were not displaced from employer coverage. To that end, the law mandated large employers to offer coverage, exempted certain "grandfathered" health plans from its regulations, and created the firewall between employer coverage and subsidized coverage. The family glitch bolsters this firewall. At the time, there was a general concern that premium subsidies would encourage some employers, especially small employers, to drop coverage.[46] If affordability were based on the cost of family coverage, the expanded access to premium subsidies for families would have created a far more powerful incentive for certain employers to drop coverage. The family glitch helped ensure the news was not filled with stories of families suddenly displaced from employer coverage and pushed into the unknown individual market.

C. Adding the family glitch balances the individual market risk pool

In designing the ACA, Congress also recognized the law needed to promote a balanced risk pool in the individual health insurance market. To be affordable and stable, health insurance markets need enough healthy, lower-risk people to offset the costs of sicker, higher-risk people. Alone, the ACA's coverage guarantees would upset this balance. The law's new requirements on insurers to guarantee coverage to everyone without charging sicker people higher premiums

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[41] Id.
[42] Congressional Budget Office, *Rules Committee Print 116-56, Patient Protection and Affordable Care Enhancement Act* (June 22, 2020), available at https://www.cbo.gov/publication/56434 (estimating fixing the family glitch would on net cost $45 billion between 2020 and 2030).
[43] Remarks by the President to a Joint Session of Congress on Health Care, September 9, 2009, available at https://obamawhitehouse.archives.gov/the-press-office/remarks-president-a-joint-session-congress-health-care.
[44] See e.g., Office of the Press Secretary, The White House, WEEKLY ADDRESS: President Obama Calls Health Insurance Reform Key to Stronger Economy and Improvement on Status Quo, August 8, 2009, available at https://obamawhitehouse.archives.gov/realitycheck/the-press-office/weekly-address-president-obama-calls-health-insurance-reform-key-stronger-economy-a.
[45] Angie Drobnic Holan, "Lie of the Year: 'If you like your health care plan, you can keep it'," PolitiFact, December 12, 2013, available at https://www.politifact.com/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/.
[46] *See* Congressional Budget Office, *Key Issues in Analyzing major Health Insurance Proposals* (December 2008), p. 45, available at https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-keyissues.pdf ("Other factors held equal, a firm would be less likely to offer coverage if the relative attractiveness of its employees' other options increased.") *See also*, Amy B. Monahan & Daniel Schwarcz, "Saving Small-Employer Health Insurance," *Iowa Law Review*, Vol. 98, No. 5 (2013).

would allow people to wait until they were sick before enrolling in coverage. This opportunity to select coverage based on health status is called adverse selection. To guard against adverse selection, the law included an individual mandate requiring healthy people to maintain coverage. It also established annual and special enrollment periods to help ensure people maintained continuous coverage throughout the year.

The family glitch further protected the individual market risk pool against adverse selection. In a November 2009 analysis, CBO and JCT estimated that about a fifth of the individual market enrollees under the ACA proposal would be covered by an employer if the law remained unchanged.[47] These people would move from employer coverage either because their employer dropped coverage or because their employer failed to offer affordable coverage. CBO and JCT projected that this flow of people would be "older and in poorer health" and, therefore, "tend to increase average medical spending and average premiums."[48] Adding the family glitch reduced this flow of people and, therefore, protected the risk pool. Importantly, because the family glitch reduced incentives for employers to drop coverage and reduced the number of people eligible for subsidies based on a lack affordable employer coverage, it helped reduce the flow of people from both sources. While there may be different projections on how fixing the family glitch would impact the risk pool today as discussed below, at the time the ACA passed Congress was generally concerned with reducing the flow of people from employer coverage to the individual market.

X. States, certain employees, and people subject to higher premiums would all have standing to challenge the rule in federal court

This analysis of the statutory text, legislative history, and purposes of the ACA clearly shows there is no legal basis to support the Agencies' proposal to fix the family glitch. If the Agencies go ahead and finalize the proposed rule, then who might come forward to mount a legal challenge? It's possible that the Agencies are betting on no one challenging the rule or that no one will have standing to challenge the rule. Regulatory actions that expand benefits can be hard to challenge in court because any plaintiff will need to demonstrate a concrete and particularized injury.[49] That means a widely shared harm like wasting tax dollars does not create standing.

So, who can claim injury when the government draws money from the treasury and increases the collective federal deficit to expand benefits? In this case, there are at least three parties who may be able claim a particularized injury, including states, employees, and people subject to higher premiums.

A. Fixing the family glitch will increase the cost of state Medicaid programs

Expanding premium subsidies will expand the number of people who apply for subsidized health insurance coverage through federal and state Exchanges. Exchanges determine eligibility for both state-funded Medicaid programs and individual market premium subsidies. A recent

[47] Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (November 30, 2009), available at https://www.cbo.gov/publication/41792.
[48] Id.
[49] Clapper v. Amnesty Intern. USA, 568 US 398 (2013).

actuarial analysis created under the direction of the Centers for Medicare & Medicaid Services (CMS) operates under the assumption that "[a]ny changes in the number of non-group applicants is likely to affect the number of consumers identified as Medicaid-eligible, and subsequent Medicaid enrollment levels."[50] Thus, a larger number of applicants due to an expansion of premiums subsidies will result in more people qualifying for both state-funded Medicaid and premium subsidies. The Urban Institute estimates these mechanics will increase Medicaid and CHIP enrollment by 93,000.[51] This will directly increase the cost of state Medicaid programs.

Federal courts have held that federal administrative actions that impose costs on state and local budgets impose an injury sufficient to establish standing. In *City of Columbus v. Cochran*, a federal district judge in Maryland held that the predictable increase in the number of uninsured due to a CMS rule creates standing to challenge the rule because the increase in the uninsured would increase costs on local health departments that provide services to the uninsured.[52] Likewise, fixing the family glitch will increase costs on state Medicaid programs by predictably increasing the number of people who apply for coverage through the Exchange and then enroll in Medicaid.

B. Certain employees will be injured when they lose access to lower cost, higher quality employer coverage

While fixing the family glitch will make health insurance more affordable for some people, it will also result in some people losing access to employer-sponsored coverage. As noted previously, establishing the family glitch helped secure existing employer-sponsored coverage by bolstering the firewall between subsidized coverage and employer coverage. Expanding premium subsidies will increase incentives for employers to drop coverage. Certain employers will find that enough employees will be better off financially with premium subsidies versus tax-advantaged employer coverage and decide to drop coverage. The Urban Institute estimates nearly 600,000 people will lose employer coverage if the family glitch is fixed.[53]

This predictable loss of employer coverage will injure certain employees in at least two ways. Higher-income employees and their dependents who don't qualify for premiums subsidies and lose employer coverage will likely be forced to pay more. Many employees and their dependents will also be harmed by losing access to higher quality coverage with lower cost sharing and broader provider networks. The average maximum out-of-pocket (MOOP) for employer

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[50] Acumen, *Estimating the Coverage Impact of Georgia's Section 1332 Waiver with the Georgia Access Model* (April 2022), available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Waiver-Acumen-Analysis.pdf.

[51] Matthew Buettgens and Jessica Banthin, *Changing the "Family Glitch" Would Make Health Coverage More Affordable for Many Families* (Urban Institute, May 2021), available at https://www.urban.org/research/publication/changing-family-glitch-would-make-health-coverage-more-affordable-many-families.

[52] City of Columbus v. Cochran, 523 F. Supp. 3d 731, 743-744 (2021).

[53] Matthew Buettgens and Jessica Banthin, *Changing the "Family Glitch" Would Make Health Coverage More Affordable for Many Families* (Urban Institute May 2021), available at https://www.urban.org/research/publication/changing-family-glitch-would-make-health-coverage-more-affordable-many-families.

coverage is often less than $2,000 and averages around $4,000.[54] By comparison, in 2022, the lowest MOOP offered on HealthCare.gov in New Hampshire is $6,300 and $6,500 in West Virginia.[55] The most popular employer plans are preferred provider organization plans with broad networks[56] while the most popular health plans offered on HealthCare.gov are health maintenance organization and exclusive provider organization plans with narrow networks.[57] The proposed rule admits "many families may prefer the benefits and provider networks of employer coverage, compared to Exchange coverage."[58] These people, if they lose coverage due to the rule, will be harmed.

C. Certain people will be forced to pay higher premiums because of changes to health insurance risk pools

Fixing the family glitch will likely injure certain people by requiring them to pay higher premiums if the rule induces sicker people to enroll in or healthier people to disenroll from their insurance plan's risk pool. It's not entirely clear how fixing the family glitch will impact the insurance risk pools, but there will almost certainly be a negative impact on some people. The Urban Institute estimates the fix would reduce premiums in the individual market by about 1 percent nationwide because new entrants would on average be healthier.[59] The Urban Institute also estimates most of these people will be switching from employer coverage. That means healthier people will be leaving employer coverage and leaving behind a sicker risk pool which will lead to higher premiums for those remaining in the pool. This premium increase constitutes a concrete and particularized economic injury to people who are enrolled in employer coverage.[60] There may be other dynamics that lead to the opposite outcome with sicker people entering the individual market and lead to higher premiums in the individual market as Congress originally aimed to avoid. In this case, the unsubsidized individual market enrollees would be the people harmed.

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[54] Kaiser Family Foundation, *Employer Health Benefits: 2021 Annual Survey* (2021), at Figures 7.44 and 7.45, available at https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/.
[55] Josh Archambault and Peter Nelson, "Expanded ACA subsidies hurt those with pre-existing conditions," *Union Leader*, November 26, 2021, available at https://www.unionleader.com/opinion/op-eds/josh-archambault-peter-nelson-expanded-aca-subsidies-hurt-those-with-pre-existing-conditions/article_34aa39ed-9513-5606-8400-24e9ae9ad432.html; and "'Build Back Better' Expanded ACA Subsidies Will Hurt Those With Pre-Existing Conditions," *Forbes.com*, November 8, 2021, available at https://www.forbes.com/sites/theapothecary/2021/11/08/build-back-better-expanded-aca-subsidies-will-hurt-those-with-pre-existing-conditions/?sh=64b07077a9af.
[56] Kaiser Family Foundation, *Employer Health Benefits: 2021 Annual Survey* (2021), at Figure 5.2, available at https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/.
[57] Edmund Haislmaier and Abigail Slagle, *Premiums, Choices, Deductibles, Care Access, and Government Dependence Under the Affordable Care Act: 2021 State-by-State Review* (Heritage Foundation, November 2, 2021), available at https://www.heritage.org/health-care-reform/report/premiums-choices-deductibles-care-access-and-government-dependence-under.
[58] 87 FR at 20360.
[59] Congressional Budget Office, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act (November 30, 2009), available at https://www.cbo.gov/publication/41792.
[60] City of Columbus v. Cochran, 523 F. Supp. 3d 731, 744 (2021).

XI. Conclusion

In 2010, Democrats in Congress resorted to a legislative process that cut corners to pass the ACA to avoid needing to reach across the aisle. When Democrats lost a filibuster-proof majority in the Senate after Republican Scott Brown filled Ted Kennedy's seat in January 2010, they turned to the budget reconciliation process. As a result, the ACA includes several policies that would likely not have become law if Democrats had allowed a House and Senate conference committee to negotiate and manage the law's competing goals.

As Justice Roberts noted in *King v. Burwell*, this process also led to "more than a few examples of inartful drafting" which, in turn, led to ambiguities.[61] However, the addition of the family glitch is not one of these ambiguities. The statutory text, legislative amendments, and the purposes served by the family glitch all show Congress clearly intended to add this policy to the ACA. After thoughtful deliberation, the Agencies agreed to this clear reading in 2013 in concert with the CBO and JCT interpretations.

Given more time to deliberate on a bipartisan basis, Congress may have removed the family glitch and gone back to the original Senate Finance Committee language which did not base affordability on the cost of self-only coverage and did not limit the special rule for related individuals to determining individual mandate exemptions. That did not happen. Rather, the family glitch became law and fixing it therefore requires Congress. We strongly urge the Agencies to not finalize this proposed rule and leave any fix with Congress

Sincerely,

/S/

Peter Nelson
Senior Policy Fellow
Center of the American Experiment

[61] King v. Burwell, 576 U.S. 473 (2015).