Professional Perspective

Fixing the ACA's Family Glitch

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In a Final Regulation issued Oct. 13, 2022, the Treasury Department and Internal Revenue Service (IRS) (collectively "The Departments") issued a final rule that fixes the so-called "family glitch," created by the way in which affordability of employer coverage for family members of an employee was determined previously under the Affordable Care Act (ACA).

Under the 2013 regulations, the cost for covering the entire family was based on the cost of covering only the employee. The final regulation reverses this position. Commencing in 2023, affordability of employer coverage for family members is determined based on the total cost of covering the employee and the related individuals.

While it is not unusual for an administrative agency to modify or change a regulatory position over time, usually in response to changing circumstances, an outright reversal is less common. The IRS made the complete about-face after receiving 3,888 comments on the proposed regulations, most of which supported the change.

This article examines the rationale advanced by the IRS in support of its changed position in the matter of the "family glitch." It also considers how the IRS's position might fare if challenged in the wake of *West Virginia v. EPA*.

Background

The ACA enacted a broad range of rules governing all aspects of health care delivery and finance in the US. A key ACA goal is to enable eligible individuals and families with low or moderate incomes to purchase affordable health insurance coverage. Congress accomplished this principally by amendments to the Code. Specifically, ACA § 1401(a), which adds 26 U.S.C. § 36B, establishes rules governing Premium Tax Credits (PTCs)—amounts that can be applied to the purchase of health insurance through state-based insurance marketplaces or exchanges.

Premium Tax Credits

PTCs are available to individuals and their family members who meet certain eligibility requirements, which includes a requirement that the individual or persons related to the individual—i.e., family members—must enroll in a qualified health plan (QHP) through a state-based exchange or marketplace and must not be eligible for other minimum essential coverage (MEC). What it means to be "eligible" for other MEC in the case of a family member—or "related individual"—is central to understanding the final regulation.

An individual's family consists of the individual, the individual's spouse—if filing jointly—and any of the individual's dependents. MEC is typically accessed through employer coverage. If an individual is eligible for employer coverage for a given month, no PTC is allowed for the individual for that month.

An individual is not treated as eligible for employer coverage if the coverage offered is unaffordable or does not provide minimum value. However, if the individual enrolls in employer coverage, the individual is treated as eligible, irrespective of whether the employer coverage is affordable or provides minimum value. The treatment of minimum value under the statute and in the final regulation is discussed below.

Under the affordability test, an employee who does not enroll in employer coverage is not treated as eligible for the coverage if the employee's required contribution exceeds 9.5% of the applicable taxpayer's household income. The required contribution percentage of 9.5 is indexed annually.

Under the prior law, the employee's share of the premium for family coverage was not considered in determining whether employer coverage was affordable for related individuals. As a result, the family coverage offered by an employer might be unaffordable to the individual's spouse and dependents, but the related individuals were still ineligible for PTCs based on the affordability of employee-only coverage. This is what came to be referred to as the family glitch, despite that it may or may not have been what Congress intended. The Kaiser Family Foundation estimated that some 5.1 million people fall into the family glitch.

Individual Mandate

Section 5000A imposes a tax penalty (shared responsibility payment) on "applicable individuals" who fail to maintain MEC. Section 5000A(d)(1) defines an applicable individual as any individual other than: an individual with a religious conscience exemption, an individual who is not lawfully present, or an individual who is incarcerated. These rules are referred to as the ACA's "individual mandate." The amount of the shared responsibility payment was reduced to zero by the Tax Cuts and Jobs Act of 2017. As a consequence, there is no longer any practical sanction or penalty imposed on individuals who go without MEC, despite that the individual mandate remains a requirement of law.

No shared responsibility payment is required in the case of an individual whose "required contribution" is less than 8.5% of the individual's household income. The term "required contribution" means the portion of the annual premium which would be paid by the individual for self-only coverage. But where an individual is eligible for MEC through an employer by reason of a relationship to an employee, the determination of affordability is made by reference to required contributions of the employee. Thus, employer coverage is affordable for those related individuals if the share of the annual premium the employee must pay to cover the employee and the related individuals is not greater than the required contribution percentage of household income. Final regulations issued under the provision are in accord.

Under the law in effect immediately prior to the final regulation, the treatment of related individuals diverged. For purposes of the individual mandate, employer coverage provided to the employee and related individual is deemed affordable if the share of the employee's total annual premium, i.e., self-only, self-plus-one, family, etc., is affordable—the share of the total annual premium does not exceed the required contribution percentage of household income.

For PTC purposes, however, employer coverage that includes related individuals is deemed affordable based solely on the cost of self-only coverage. This difference figures prominently in the rationale underlying the final regulation. By way of example, assume a family of five has household income of $60,000 in 2023. This puts them at about 148% of the 2023 Federal Poverty Limit. Parent P's employer offers major medical coverage that requires P to pay $100 per month for self only coverage, or 2% of household income.

This is significantly less than the 9.12% 2023 affordability threshold. P's employer charges an additional $900/month to add the spouse and children to the employer's coverage, or 20% of the P family household income. Under the prior, final regulation, the entire family is treated as having access to affordable employer-sponsored health insurance, because the affordability determination is based solely on the cost of self-only coverage. No member of P's family can qualify for a PTC in 2023.

The Final Regulation

Reduced to its essentials, the Final Regulation's reversal turns on the flush language immediately following 26 U.S.C. § 36B(c)(2)(C)(i)(II), which reads, "[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." The Departments are of the view that this language "fails to state clearly and expressly how § 36B(c)(2)(C)(i)(II) applies to related individuals or how the cross-reference to § 5000A(e)(1)(B) applies to coverage for related individuals."

Simply put, the Departments are claiming that the statute is ambiguous on the subject of how to determine whether employer-provided group health plan coverage is affordable for family members. It therefore falls to the Departments to clarify the ambiguity. As explained below, where statutory language is silent or ambiguous, a court will uphold an agency's interpretation if the agency's interpretation is based on a permissible construction of the statute.

The preamble provides a detailed explanation of the Departments' rationale in support of the reversal of prior law. The Departments' claim that the above-cited forthright language provides "[t]his clause shall also apply to a [related individual]." Thus, 26 U.S.C. § 36B(c)(2)(C)(i) may be read to apply to a related individual as follows:

> [A related individual] shall not be treated as eligible for minimum essential coverage if such coverage (I) consists of an eligible employer-sponsored plan [ ], and (II) 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.

Thus, claim the Departments, the reference to MEC, as it applies to related individuals, is the coverage the related individual may enroll in, which is the family coverage offered by the employer. The Departments make the further claim that this

reading gives full effect to "section 36B(c)(2)(C)(i)(II)'s cross reference to section 5000A(e)(1)(B). This claim assumes that Congress did not intend for the rules governing PTCs to work differently than the rules governing the ACA's individual mandate.

In arriving at its conclusion that the approach first taken in the proposed rule and subsequently adopted in the Final Regulation represents the better reading of the statute, the Departments found themselves having to fend off a series of objections, which include the following:

Section 36B(c)(2)(C)(i)(II) does not cross reference § 5000A(e)(1)(C). This claim is correct, of course. The cross reference defining the term "required contribution" is to § 5000A(e)(1)(B). Under basic canons of statutory interpretation, wouldn't the reference to § 5000A(e)(1)(A) in § 5000A(e)(1)(C) preclude the use of the rule in § 5000A(e)(1)(C) for some other purpose, e.g., providing a rationale for an affordability test for related individuals that is separate from the test for employees? The Departments demur, saying that the definition of "required contribution" in § 5000A(e)(1)(B)(i) is modified by, or baked into, § 5000A(e)(1)(C). As a result, there is no need for a separate cross reference.

The QSEHRA rules follow prior law. A comment suggests that affordability of related individuals in the context of qualified small employer health reimbursement arrangements (QSEHRAs) should inform the way the PTC is determined under the Final Regulation. In the case of a QSEHRA, coverage is affordable for a month with reference to the cost of the monthly premium for the second lowest cost silver plan for self-only coverage of the employee offered in the state-based exchange for the rating area in which the employee resides. 26 U.S.C. § 36B(c)(4)(A).

The Departments counter that the QSEHRA rules do not cross reference § 5000A(e)(1)(B), nor do they include any rule governing affordability for related individuals. Instead, it provides the same affordability rule for both employees and related individuals by stating that affordability for coverage under a QSEHRA for "an employee (or any spouse or dependent of such employee)" is based on the cost of self-only coverage of the employee. It is therefore reasonable to conclude that the two affordability rules are simply not the same.

The Final Regulation is inconsistent with the ACA legislative history. A commenter also argued that the legislative history—another key tool in statutory interpretation—underlying the ACA shows that Congress intended that the rule for affordability of employer coverage for family members be based on the cost of self-only coverage to the employee. While it does appear that an earlier version of the ACA would have based the determination of the affordability on self-only coverage, the statute as finally enacted was less clear on the subject. The Departments were frankly unpersuaded.

The affordability rule for related individuals should be accomplished by legislation rather than by regulation. Several commenters argued that, despite requests to amend § 36B to provide that affordability of employer coverage for related individuals is based on the employee's cost for family coverage, Congress has not amended § 36B to enact this result. While the Departments acknowledge that members of Congress have included language in various bills to address the § 36B affordability rule, this does not mean that the § 36B affordability test for related individuals must be addressed in legislation.

They also rely on Supreme Court precedent to the effect that:

> "[F]ailed legislative proposals are a particularly dangerous ground on which to rest an interpretation of a prior statute [internal quotations omitted] . . . Congressional inaction lacks persuasive significance because several equally tenable inferences may be drawn from that inaction, including the inference that the existing legislation already incorporated the offered change."
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> *Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 187 (1994)

While reliance on the Supreme Court to buttress the regulators position is compelling in the context of the preamble to the Final Regulation, the reliance on the court could cut both ways for the reasons explained below.

Interpretation of Joint Committee on Taxation Report. In a footnote in the preamble to the proposed regulations, the Departments observed that a March 21, 2010, issued by the Joint Committee on Taxation, had initially taken the position that affordability is defined as coverage with a premium required to be paid by the employee that is 9.5% or more of the employee's household income, "based on the type of coverage applicable (e.g., individual or family coverage)."

The Joint Committee staff later revised the quoted language to base affordability on the premium required to be paid by the employee based on self-only coverage. While the Departments acknowledged the Joint Committee on Taxation's change in position, they were unwilling to characterize the change as correction of an error.

There were a handful of other objections, principally based in the interaction of the rules governing PTCs with other, related provisions of law, none of which the government found persuasive.

Minimum Value

Minimum value is, at bottom, a measure of a health plan's generosity. Minimum value is defined by § 36B(c)(2)(C)(ii) to mean an actuarially determined value that is based on the health care costs of a standard population. Under § 36B(c)(2)(C)(ii) and § 1.36B–6(a)(1), employer-sponsored coverage provides minimum value if the plan's share of the total allowed costs of benefits provided to an employee is at least 60%, regardless of the total allowed costs of benefits.

On Nov. 26, 2014, Department of Health and Human Services (HHS) issued proposed regulations providing that an eligible employer-sponsored plan provides minimum value only if, in addition to covering at least 60% of the total allowed costs of benefits provided under the plan, the plan benefits include substantial coverage of inpatient hospital services and physician services. This was followed, on Feb. 27, 2015, by a final rule. The Departments thereafter issued a proposed regulation incorporating the substance of HHS' final rule.

The Final Regulation adopts the IRS' 2015 proposed rule. Importantly, the rule as finalized applies the same minimum value standard to both employees and related individuals based on the costs of benefits provided to employees and related individuals, respectively. The statute does not mention family members, however. Nevertheless, the IRS previously interpreted 26 U.S.C. § 36B(c)(2)(C)(ii)'s minimum value requirement to extend to coverage for both employees and family members. Thus, a PTC would not be allowed for a related individual offered coverage under a plan that was affordable but provided minimum value only to employees and not to related individuals.

Noting that rule was promulgated in 2012, that it had not previously been objected to, and a different rule would be inconsistent with the ACA's goals, the regulators rejected the argument. The Final Regulation establishes a minimum value rule that includes family coverage.

While the final rule adopts the minimum value policies outlined in the proposed rule without change, it also added a separate test for minimum value: one for employees and one for family members. The change serves to seamlessly integrate the minimum value rule affordability rules.

Judicial Review of Agency Act, Chevron Deference & Impact of *West Virginia v. EPA*

A 1984 case, *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), established a framework for judicial review of an agency's interpretation of a statute over which it has interpretive jurisdiction. Specifically, *Chevron* adopted a two-step analysis to determine whether a court must defer to an agency's statutory interpretation.

- **Step 1.** The court asks whether the statute directly addresses the precise issue before the court. If the statute is clear, then no deference is owed. But if the statute is ambiguous or silent in respect of the matter before the court, the court must proceed to step two.
- **Step 2.** Courts must generally defer to the agency's reasonable interpretation of the statute.

In the case of a challenge to the Final Regulation and leaving aside the question of who might have standing to bring such a challenge, a court applying step 1 would ask whether the statute, here 26 U.S.C. § 36B, directly addresses the precise issue before the court or whether the statute is ambiguous or silent in the matter. While reasonable minds might differ, the fact that even the Joint Committee on Tax had a change of heart might lead a court to determine that the statute is ambiguous.

Under step 2, that same court might well determine that the Departments' approach represents a reasonable interpretation of the statute. Indeed, much of the preamble to the Final Regulation could be read as the first draft of a brief in support of the rule under *Chevron*. But what the preamble seems to miss entirely is the impact of the "major questions doctrine."

Determining the contours of the major questions doctrine will likely take decades as litigants spar over its boundaries. While the Final Regulation rule does not involve a significant portion of the US economy; it does involve a matter of at least some significant political significance; it does involve an agency claiming power to do something it has never done before; and it does adopt a regulatory program that Congress had conspicuously declined to enact itself. Thus, at a minimum, the case presents another obstacle to a court's acceptance of the Departments' handiwork.

Conclusion

While there is no shortage of anecdotal evidence to support that view that the disparate treatment of related individuals for purposes of the PTC and the individual mandate, the record is less than clear. There was, for example, some worry that employers would increase the contributions required to enroll family members thereby encouraging employees and their family members to drop employer coverage and instead purchase coverage from exchanges.

Significantly, the fix for the "family glitch" that the Departments settled on does not affect employers' costs. That is, the Final Regulation does not make and changes to the ACA's employer shared responsibility rules. An employer's offer of coverage may well be deemed affordable for purposes or avoid an excise tax under § 4980(b), but that same coverage may not be deemed affordable for purposes of denying a family member access to a PTC for coverage purchased through an exchange.

Affordability for the purposes of the ACA employer shared responsibility rules is still determined based on the cost of self-only coverage. As a result, employers and their advisors are little affected by the Final Regulation. There is thus a dearth of parties with any incentive to object. Of course, the Departments' approach could be upended by a future administration's regulation.