Afforda ility of E ployer Coverage for Fa ily Me er of E ployee

A Propo ed Rule y the Internal Revenue Servi,e

Do,u ent URL http ://www.federalregi ter.gov/d/2022-07158
Pu li hed On 2022-04-07

Co ent Tra,king Nu er `l - g -fv m`

Co ent Su i ion Date 2022-06-06

the Internal Revenue Servi,e doe not pu li h ,o ent on Regulation .gov. To ,he,k the tatu of your ,o ent or o tain further infor ation, plea e follow-up dire,tly with the agen,y ,onta,t li ted in the do,u ent you u itted a ,o ent for.

Submitted via regulations.gov

June 6, 2022

CC:PA:LPD:PR (REG-114339-21)
Room 5203, Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
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

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

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 (li)5 5huua05 T

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

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.*

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

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.

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). "W

APPENDIX A – INDIVIDUAL COMMENTERS

Deans

1. Ayman El-Mohandes, MBBCh, MD, MPH, Dean, CUNY Graduate School of Public Health & Health Policy
2. Barbara K. Rimer, DrPH, MPH, Dean and Alumni Distinguished Professor, UNC Gillings School of Global Public Health
3. Boris Lushniak, MD, MPH, Professor and Dean, University of Maryland School of Public Health
4. Edith A. Parker, MPH, DrPH, Dean and Professor of Community and Behavioral Health, University of Iowa College of Public Health
5. G. Thomas Chandler, MS, PhD, Dean and Professor of Environmental Health Sciences, Arnold School of Public Health, University of South Carolina
6. Hilary Godwin, PhD, Dean, University of Washington School of Public Health
7. Jane Thorpe, JD, Sr. Associate Dean for Academic, Student & Faculty Affairs, Professor and of Health and Management, Milken Institu (r)-,titu (r)-,t8(r)- (P)11 (n n)1 (ubl)3 ((c)-1 ( )5 (42 (e)-1

5. Becky Slifkin, PhD, Professor, Department of Health Policy and Management, UNC Gillings School of Global Health

22. Lynn A. Blewett, PhD, MA, Professor of Health Policy, University of Minnesota School of Public Health

23. Mark A. Peterson, PhD, Professor of Public Policy, Political Science, and Law, Department of Public Policy, UCLA Meyer and Renee Luskin School of Public Affairs

24. Maureen Byrnes, MPA, Teaching Instructor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

25. Melissa M. Goldstein, JD, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

26. Michael R. Ulrich, JD, MPH, Assistant Professor, Center for Health Law, Ethics, & Human Rights, Boston University School of Public Health, Distinguished Visiting Scholar, Solomon Center for Health Law & Policy, Yale Law School

27. Naomi Seiler, JD, Associate Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

28. Neal Halfon, MD, MPH, Professor of Pediatrics, Public Health and Public Policy, Director, UCLA Center for Healthier Children, Families & Communities, UCLA

29.

37. Timothy M. Westmoreland, JD, Professor from Practice, Georgetown University School of Law

38. Wendy K. Mariner, JD, LLM, MPH, Professor Emerita, Health, Law, Ethics, and Human Rights, Boston University School of Public Health, Professor of Law, Boston University School of Law, Professor of Medicine, Boston University School of Medicine