

May 25, 2022

The Honorable Charles P. Rettig  
Commissioner  
Internal Revenue Service  
Department of the Treasury  
1111 Constitution Avenue NW  
Washington, DC 20224

***RE: Affordability of Employer Coverage for Family Members of Employees (REG-114339-21)***

Dear Commissioner Rettig:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, we thank you for the opportunity to comment on the Internal Revenue Service's (IRS) proposed rule amending how employer coverage affordability would be measured for family members of employees. **The AHA has long advocated for a fix to the current methodology for assessing affordability of employer coverage for family members, often referred to as the “family glitch,” which is estimated to affect about 5 million individuals. We commend the IRS on proposing to revise this regulation and improve access to health insurance coverage for millions of American families.**

We recognize that this regulation is just one piece of a much broader plan to increase access to affordable, comprehensive coverage through the marketplaces. In addition to fixing the “family glitch,” we appreciate the steps the Administration has already taken, including expanding the annual open enrollment period, establishing additional special enrollment periods, repealing the direct enrollment option and section 1332 waiver policy changes, and significantly increasing funding for outreach and enrollment efforts. We know that there is still more to be done and we look forward to continuing to partner with you on this important objective.

See below for our detailed comments.



### **The NPRM Reflects the Best Reading of the Affordable Care Act**

The AHA agrees that the proposed regulation reflects the “better reading” of the relevant Affordable Care Act provisions, 87 Fed. Reg. 20354, 20357. In particular, the proposed regulation correctly recognizes that “the parenthetical cross reference in section 36B(c)(2)(C)(i)(II) to section 5000A(e)(1)(B)(i) is understood to incorporate the special rule in section 5000A(e)(1)(C) that modifies the required contribution rule in section 5000A(e)(1)(B)(i) when the coverage in question is for related individuals.” *Id.* This interpretation best captures “the language and design of the statute as a whole,” *Bethesda Hosp. Ass’n v. Bowen*, 485 U.S. 399, 405 (1988).

By contrast, the Department’s prior reading does not correctly interpret the qualifications that Section 5000A(e)(1)(C) places on Section 5000A(e)(1)(B)(i) via an express cross-reference, thereby violating the bedrock principle of statutory interpretation that “text[s] must be construed as a whole,” A. Scalia & B. Garner, *Reading Law* 167 (2012); see *id.* (“Perhaps no interpretive fault is more common than the failure to follow the whole-text canon, which calls on the judicial interpreter to consider the entire text, in view of its structure and of the physical and logical relation of its many parts.”). Thus, while the Department may be right that the relevant provisions are susceptible of “two different readings,” 87 Fed. Reg. at 20357, the agency is not simply waiving the “ambiguity flag,” *Kisor v. Wilkie*, 588 U.S. (2019), 139 S. Ct. 2400, 2415 (2019). Instead, for the reasons explained in the NPRM and in this letter, the text, structure and purpose of the statute support the Department’s new — and more consistent — interpretation.

The Department’s new reading is bolstered by a critical factor that the agency does not discuss in its NPRM — namely, the interpretive principles set forth in *King v. Burwell*, 576 U.S. 47 (2015). In that case, which was decided *after* the Department’s prior regulation was promulgated, the Supreme Court forthrightly acknowledged that the Affordable Care Act (ACA) is “far from a *chef d’oeuvre* of legislative draftsmanship.” *Id.* at 493 n.3 (quotation marks omitted). It explained:

Several features of the Act’s passage contributed to that unfortunate reality. Congress wrote key parts of the Act behind closed doors, rather than through “the traditional legislative process.” Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 L. Lib. J. 131, 163 (2013). And Congress passed much of the Act using a complicated budgetary procedure known as “reconciliation,” which limited opportunities for debate and amendment, and bypassed the Senate’s normal 60–vote filibuster requirement. *Id.*, at 159167. As a result, the Act does not reflect the type of care and deliberation that one might expect of such significant legislation.

*Id.* at 491-92. Just as in *King v. Burwell*, these factors may have contributed to the imperfect drafting of the provisions at issue here, which in turn contributed to the Department's earlier interpretation that led to the "family glitch."<sup>1</sup>

Nevertheless, *King v. Burwell* held that courts (and agencies) "must do our best, bearing in mind the fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme," *Id.* at 492 (quotation marks omitted). Here, the context and overall statutory scheme — particularly the qualifications to Section 5000A(e)(1)(B) provided in the "special rules for individuals related to employees" in Section 5000A(e)(1)(C) — confirm that the NPRM's interpretation is by far the better one.

Importantly, *King v. Burwell* concluded with a clear interpretative directive. It held: "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. *If at all possible*, we must interpret the Act in a way that is consistent with the

---

<sup>1</sup> The conflicting Joint Committee on Taxation (JCT) reports discussed in the NRPM (at 20358 n.5) are a perfect example of how the process shortcomings described in *King* leads to difficulty in parsing the ACA's language even for those, like the JCT, who were closely involved in the drafting process. As the Department notes, the JCT report initially adopted the reading of the ACA reflected in this NPRM. That interpretation was changed two months later to reflect the alternate reading in the Department's initial regulation. Critically, that alternate reading was adopted *after* Congress passed the ACA, which means Congress was not aware of that reading when it voted on the ACA. See Avik Roy, Obama Bombshell: 4 Million People Who Thought They Were Gaining Coverage, Won't, *Forbes*, August 10, 2011, at <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=5dc305ac23b1> ("In a report the JCT published on March 21, 2010, the Committee used the more straightforward, broader definition of 'unaffordability' that took into account the family plan example I described above. However, on May 4, 2010, several weeks after PPACA was signed into law, JCT issued a correction, stating that the March 21 interpretation was wrong, and should be replaced with 'self-only coverage.'")

The NPRM contends that these dueling reports "renders either interpretation available under the ACA," 87 Fed. Reg. 20358 n.5. While that may be true, we believe that this statutory history is clear evidence of how the features of the AHA's passage, discussed in *King*, led the Department astray when it initially adopted the alternate interpretation. Because the voting Congress never saw the revised JCT report at the time of enactment, the JCT's original interpretation is the only one that can be relevant to statutory analysis, e.g., *Abrego Abrego v. The Dow Chemical Co.*, 443 F.3d 676, 685 (9th Cir.2006) (congressional report "entitled to exceptionally little weight" where it was issued 10 days after the statute was passed and thus "not available for consideration or discussion before enactment"); see also *Clarke v. Securities Indus. Ass'n*, 479 U.S. 388, 407 (1987) ("Respondent also relies on the following statement, which Representative McFadden placed in the Congressional Record 10 days after the passage of the McFadden Act ... We do not attach substantial weight to this statement, which Congress did not have before it in passing the McFadden Act."); see generally *Covalt v. Carey Canada Inc.*, 860 F.2d 1434, 1438 (7th Cir. 1988) ("Legislative history is valuable only to the extent it reveals the background of the law and the assumptions shared by those who wrote and voted on the bills ... Statements and thoughts that not only did not but also could not have come to the attention of Congress at the time do not reveal the process of deliberations. By definition, words written after the vote and the President's signature were unimportant in the process leading to the vote.").

former, and avoids the latter,” *King*, 576 U.S. at 498 (emphasis added). For the reasons discussed in the NPRM<sup>2</sup>, the interpretation in the proposed regulation would undoubtedly improve health care markets by expanding access to affordable coverage. Because the relevant provisions “can fairly be read consistent with what we see as Congress’s plan,” *id.*, the Department’s new reading is, at a minimum, legally permissible. But as explained above, it is more than merely “possible” to interpret the Act consistent with Congress’ purposes; the Department’s proposed interpretation is the *best* reading of the Affordable Care Act. That “is the reading the [Department]” should “adopt.” *Id.*

### **Minimum Value Standards Must Include Inpatient Hospital and Physician Services**

The IRS is again proposing to clarify that for employer health plans to meet the minimum value to qualify for minimum essential coverage, they must provide substantial coverage for inpatient hospitalization and physician services. **The AHA remains supportive of this policy.** Inpatient hospital coverage is critical to the health care continuum and is included specifically in the ACA’s definition of essential health benefits. As advocated by the AHA, CMS stopped the proliferation of plans without substantial coverage for inpatient hospitalization and physician services in the final Notice of Benefit and Payment Parameters for 2016, stating that health plans must not only continue to meet the 60 percent actuarial value standard, but must also include “substantial coverage” for both inpatient hospital and physician services. We appreciate the IRS again proposing to align with the CMS definition.

### **More Work is Needed to Increase Access to Affordable, Comprehensive Coverage**

The AHA is committed to closing the remaining coverage gaps and ensuring that health insurance coverage is affordable and works well for consumers. While outside of the scope of this regulation, we urge the Administration to address in the future two critical issues that undermine the comprehensiveness of coverage: substandard coverage and unaffordable and confusing cost-sharing structures.

Hospitals and health systems remain deeply concerned about the proliferation of substandard coverage options over the last several years, such as short-term, limited duration health plans and health sharing ministries. These “plans” provide inadequate access to care and can subject consumers to significant out-of-pocket spending when illness or injury occur. Hospitals and health systems report that patients enrolled in these products often find themselves without coverage for emergency services, cancer care and

---

<sup>2</sup> See, e.g., 87 Fed. Reg. at 20356 (“In addition, the current approach has undermined access to more affordable health care coverage by preventing access to lower-premium subsidized Exchange plans. Under the current regulations, a PTC is not allowed for children and other family members who have been offered employer coverage if the cost of the employee’s self-only coverage is affordable, regardless of the employee’s cost to cover those family members. Many of these families purchase health insurance, either through a family member’s job or an Exchange, but pay high portions of their income towards premiums. Other families forgo coverage altogether due to the high premium costs.”); *id.* at 20357 (“[T]he proposed amendment would also support efforts to achieve the goal of the ACA to provide affordable, quality health care for all Americans.”).

The Honorable Charles P. Rettig

May 25, 2022

Page 5 of 5

hospital stays, among other services. It is [well documented](#) that the sponsors of these products often mislead individuals into purchasing these plans, which often lack basic consumer protections and, as a result, put consumers at risk of high, unexpected out-of-pocket costs and uncertainty about their coverage. **The AHA urges the Administration to limit the availability of these plans and help educate consumers about their drawbacks.**

Similarly, we must address out-of-control cost-sharing. We are deeply concerned with both the amount and the complexity of patient cost-sharing. Patients struggle to understand their health plan benefit structures and avoid care as a result of uncertainty around whether they have a cost-sharing obligation and concern about how large that obligation will be. Increasingly we are hearing reports of commercial health insurers implementing confusing and convoluted policies such as mid-year coverage changes and complex cost-sharing and network structures that leave patients unsure of whether providers are in-network or how much the patients may have to pay. Patients also express confusion around how their coverage works, including which services are subject to their deductibles and the interaction between point-of-service co-pays, co-insurance and deductibles. This uncertainty leads to hesitancy about seeking care at all.

We urge you to address these issues through health plan benefit reforms, beginning with high-deductible health plans (HDHPs) and out-of-pocket maximums. HDHPs are often marketed — inaccurately — as more cost-effective options for lower income individuals and families. Coupled with increasingly high out-of-pocket maximums, many people find themselves with health coverage that they cannot use or that subjects them to unexpected medical bills, creating undue financial and emotional stress. The AHA strongly supports changes in policy to reduce out-of-pocket maximums for individuals and families and restrict the sale of HDHPs to those individuals who can demonstrate the ability to meet their cost-sharing limits.

**We commend the IRS on its proposal to fix the “family glitch” and increase access to affordable health insurance coverage for millions of Americans.** We look forward to other opportunities to work together to achieve affordable, universal coverage through the framework established under the Affordable Care Act. Please contact me if you have questions, or feel free to have a member of your team contact Ariel Levin, AHA’s senior associate director of policy, at 202-626-2335 or [alevin@aha.org](mailto:alevin@aha.org).

Sincerely,

/s/

Stacey Hughes  
Executive Vice President

CC: Administrator Chiquita Brooks-LaSure, Centers for Medicare and Medicaid Services