Affordability of Employer Coverage – The "Family Glitch" Fix Frequently Asked Questions

Overview

On October 13, 2022, the U.S. Department of Treasury, bureau of Internal Revenue Service (IRS), released a final rule to address the "family glitch" issue. The family glitch deemed employer-sponsored coverage to be "affordable" for the employee even it was not for their family members, which disqualified those family members from eligibility for financial assistance through marketplace coverage (Advance Premium Tax Credits and Cost Sharing Reduction). The new rule, effective December 12, 2022, **extends the Affordable Care Act (ACA) affordability definition** from being based solely on employee-only coverage, **to include family members** of the tax household. Beginning plan year 2023, if an employee must pay more than a predetermined affordability threshold of household income towards the premium for the lowest cost family plan offered by their employer, the plan is considered unaffordable, and the employee's family members may therefore qualify for financial assistance for health coverage through Covered California. The affordability threshold for plan year 2023 is 9.12% and will be updated every year.

This document answers common questions that Covered California has received on the fix to the family glitch.

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There are no requirements for the employers to notify the employees of the option of dependent coverage through Covered California. However, if the employee is terminating their ESC coverage, state law requires the health care service plan (in both individual and group health market) to notify the terminating enrollees that they may be eligible for reduced-cost coverage through Covered California or no-cost coverage through Medi-Cal. (Health & Safety Code, § 1366.50(a).) 12

FREQUENTLY ASKED QUESTIONS (FAQ) AND ANSWERS

What is the family glitch?

Under the Affordable Care Act (ACA), if an employee has an offer of health coverage from their employer that meets the affordability threshold, the consumer would not qualify for financial help for health coverage through Covered California.

The "family glitch" resulted from the Internal Revenue Service (IRS) final rule published in early 2013, based on the language of the ACA. Per the 2013 interpretation, if the employee-only health coverage was considered affordable, the employee and their family members were ineligible for financial assistance, even if the cost of family coverage was considered unaffordable. This is referred to as the "family glitch".

In 2022, an employer's plan was considered "affordable" if the employee didn't have to pay more than 9.61% of household income towards the premium for the lowest cost employee-only plan offered by their employer.

How was the family glitch created?

There are two main sections of the law that are involved: Sections 36B of the Internal Revenue Code deals with subsidies, and 5000A deals with the individual mandate and penalty. In 36B, the law states that an employer plan is affordable as long as the employee's required contribution doesn't exceed 9.5% of income (indexed annually; 9.12% in 2023). "Required contribution" referred to the definition in 5000A, which states that it's the amount that must be paid for the lowest cost *self-only* coverage. Although there was a lot of ambiguity in terms of how affordability of employer-sponsored plans should be determined, the wording was changed to indicate that the cost of self-only coverage would be used regardless of the employee's circumstances.

What is the new rule that fixes the family glitch?

The *Affordability of Employer Coverage for Family Members of Employees* rule revises the current interpretation of eligibility for premium tax credits for families and allows family members of an

employee to receive federal subsidies if employer-offered family coverage exceeds the affordability threshold. Instead of basing the affordability determination for a family's employer-sponsored health insurance on just the cost to cover the employee, the determination is made based on the cost to cover the employee **plus** family members of the tax household. This fix will not change the affordability threshold for employees, only for family members of the employee.

When will the new rule take effect?

The new rule takes effect December 12, 2022. So, when families apply for 2023 coverage during the Open Enrollment period, the new rules will be used to determine whether anyone in the household qualifies for a premium subsidy. Please note the 2023 employee's required contribution (affordability threshold) should not exceed 9.12%.

Will there be a separate affordability determination for the employee and for family members?

Yes, there is a separate affordability determination (calculation) for the employee (based on self-only coverage), and for family members (based on the total cost of family coverage). So, depending on how an employer subsidizes the cost of family coverage, it's possible that coverage could be considered affordable for the employee but not for family members. In that case, the family members would potentially be eligible for a premium tax credit in the marketplace, but the employee would not.

Are there any changes to the employer mandate?

No, nothing changes about the ACA employer mandate. Large employers must still provide affordable, minimum value coverage to their full-time employees, and offer coverage to those employees' dependents (offering coverage to spouses is optional). But there are still no affordability requirements for the coverage offered to dependents. The employer mandate penalty is only triggered if an employee's coverage is unaffordable, and they receive a premium tax credit in the marketplace. There is no mechanism for triggering the penalty based on an employee's family members receiving premium tax credits in the marketplace.

What is Minimum Essential Coverage offered by large group employers?

Minimum Essential Coverage (MEC) is the coverage an individual must have to comply with the individual mandate penalty tax – and that large employers may be required to offer to avoid the employer mandate ("employer shared responsibility") penalty.

What is minimum value?

Minimum value is the 60% Actuarial Value and is met when a plan pays on average at least 60% of the actuarial value of allowed benefits under the plan.

Is the cost to cover non-dependent family members taken into consideration?

No, the cost to cover non-dependent family members will not be taken into consideration. So, for example, young adults can remain on a parent's health plan until they turn 26 but are generally not considered a tax dependent for the last few years of that window. Therefore, if they enroll in the family plan, the cost to cover them is not counted when the affordability of the family plan is determined. Young adults in this situation can apply for premium subsidies in the marketplace based on their own income and family size (their own tax household), and the fact that they have the option to be added to a parent's employer-sponsored health insurance is not taken into consideration to determine their eligibility for APTC/CSR unless they enroll in their parent's ESC.

Who is affected by the family glitch?

California has roughly 593,000 people falling into the family glitch. They are disproportionately lower-income, because lower-wage workers must spend a larger percentage of their income to pay for health insurance if subsidies aren't available, and because higher-income workers are more likely to work for companies that heavily subsidize coverage for dependents. More than half of those affected by the family glitch are 0 to 18 years (54%), while 9% are uninsured. The vast majority (85%) are enrolled in employer-sponsored health insurance.

How is the affordability of employer-sponsored coverage measured?

Employer-sponsored coverage is considered to be affordable to the employee if the employee's share of the premium is equal to or less than 9.12 percent of the employee's household income in 2023, regardless of the cost to cover family members. If coverage is affordable and meets minimum value, the employee is not eligible for a premium tax credit. For example:

- Jose and Alma Reyes are married and have two children. Jose has an annual salary of $25,000. Alma earns $10,000 from part-time work. Jose's share of the premium for his employer-sponsored health insurance is $2,500 per year to cover only him (or 7.1 percent of household income). Jose's health insurance is considered affordable because it costs less than 9.12 percent of Jose and Alma's household income, even though it is 10 percent of Jose's income alone. If their household income decreases — for example, if Alma loses her job — then Jose's insurance would not be considered affordable. In that situation Jose and Alma could "jump the firewall" and become eligible for a premium tax credit.

How do you measure the affordability of family coverage offered by an employer?

Employee-only coverage is considered to be affordable if it does not cost more than 9.12 percent of household income in 2023. If an employer offers family coverage, including self plus-one plans, the coverage is considered affordable if an employee's required contribution does not exceed 9.12 percent of household income for coverage of the employee and all other individuals included in the employee's coverage who are offered the coverage.

- Jose and Alma are married and have two children. Jose and Alma have combined annual income of $35,000. Jose's employer offers employee-only and family coverage. Employee-only insurance costs $2,500 per year (7.1 percent of household income) and coverage for the entire family costs $6,000 per year (17 percent of family income). Family coverage is not considered affordable, because it costs more than 9.12 percent of household income. Because the family coverage offered is unaffordable, Alma and the children are eligible for a premium tax credit.

If a family has multiple sources of insurance for which they pay multiple premiums, do those costs factor into the affordability test?

If the family has multiple sources of employer-sponsored insurance, such as when both spouses are employed and have offers of health insurance from their respective employers, all offers of employer-sponsored insurance will be considered when determining affordability. But all other sources of health insurance that are not through an employer, such as Medi-Cal, CHIP, VA coverage, or Medicare will not be considered. The affordability test for eligibility for premium tax credits is limited to the cost of all available employer-sponsored coverage as compared to the household income.

Does employer-sponsored coverage have to fail *both* the affordability and minimum value tests to allow an employee and dependents to become eligible for a premium tax credit?

No, the offer of employer-sponsored coverage does not need to fail both tests. If an employer-sponsored plan fails to meet either the affordability or minimum value test, an employee can qualify for premium tax credits. For example, if an employer offers a plan that is very low-cost for the employee but has a minimum value of less than 60 percent, the employee can turn down the plan and qualify for a premium tax credit. However, if the employee enrolls in the plan, the employee will not be eligible for a premium tax credit. During the marketplace open enrollment period, an employee who enrolls in an employer plan that is not affordable or does not provide minimum value can drop that plan and enroll in a marketplace qualified health plan (QHP) with a premium tax credit, assuming the employee meets all other eligibility requirements.

How will the marketplace confirm whether an applicant for the premium tax credit has employer-sponsored insurance?

When a person fills out the marketplace application, they are asked questions about any offers of employer-sponsored coverage. The application asks if insurance is offered, whether it meets minimum value, its cost, and whether any waiting period applies to determine whether the employee is eligible for a premium tax credit despite having an offer of coverage. The marketplace will use information to determine whether the offer bars eligibility for PTC.

If the person doesn't have that information readily available, they can request download a form called the Employer Coverage Tool to be completed by the applicant's employer or with the employer's help. If the employer doesn't assist in completing the document, the applicant can try to find this information in other ways. For example, the employee can find premium costs in information provided during their

most recent open enrollment period. In addition, the minimum value of every plan should be on its Summary of Benefits and Coverage (SBC), a document that all plans — including employer-sponsored plans — are required to produce.

Can a person enroll and qualify for a premium tax credit if he or she was offered employer-sponsored coverage but missed the employer's open enrollment period?

In general, no. Some people may have missed their opportunity to enroll in their employer-sponsored plan. However, if the insurance offered by the employer was affordable and met minimum value, that employer offer still counts as an offer of minimum essential coverage that prevents a person from being eligible for a premium tax credit. A person in this position may enroll in marketplace coverage during an open or special enrollment period but will be ineligible for financial help.

If an employee in a family is offered affordable self-only coverage, is the employee eligible for premium tax credits?

No, the family would have to purchase two policies — one for the employee through the employer and one through the marketplace for the remaining family members. The family also may have to meet two deductibles, be subject to two out-of-pocket limits, and might have two different provider networks. Also, if the employee is offered affordable coverage with minimum value, but turns it down, signs up for an individual plan through Covered California, and receives financial help to pay for that plan, they may have to pay back some or all the tax credits or subsidies received when they file their state and federal taxes.

Does the affordability threshold change each year?

Yes. The threshold changes each year. For 2022 the threshold was 9.61%. For 2023 it is 9.12 %.

Separate Affordability Tests for the Employee and Other Members of the Tax Family.

The Marketplace applies two separate affordability tests for each ESC offer to a family:

- **Employee:** Ask the employee's contribution for the lowest-cost minimum value self-only coverage. If it meets the affordability threshold, then APTC is denied to the employee.
- **Spouse and Dependent:** Ask the premium for the lowest-cost minimum value coverage for the employee's full tax family. If it meets the affordability threshold, then APTC is denied to members of the employee's tax family who are offered the ESC.

If a spouse also has an offer of affordable coverage, how will it affect affordability calculations?

The spouse is not eligible for subsidies since they have an offer of affordable coverage.

What if some family members are on a marketplace plan and others are covered under one or more employer-sponsored plans and/or Medicare?

Affordability of employer-sponsored insurance (whether employee only or family plan) is based on the plans that are offered through an employer to the employee and their spouse and dependents. All other insurance not offered through an employer, such as Medi-Cal, Medicare, or a plan through the individual market will not be considered.

- **Example**: Jose and Alma Reyes are married and have one adult 21-year-old son, Diego. Jose has an annual salary of $35,000. Alma earns $10,000 from part-time work. Diego is disabled and receives $8,500 in disability benefits. Diego is enrolled in Medicare due to his disability. Jose's share of the premium for his employer-sponsored health insurance is $3,000 per year to cover only him (or 5.61% of their household income). Jose's share of the premium for a family coverage through his employer to cover himself, his wife, and his son is $6,000 per year (or 11.21% of their household income). Jose's health insurance is considered affordable for himself because it costs less than 9.12% of Jose and Alma's household income, which includes Diego's disability income. However, Jose has to pay more than 9.12% of their household income to cover Alma under his employer's family coverage, even without Diego. Therefore, the employer's coverage is considered unaffordable for Alma. Even though Jose does not qualify for APTC/CSR through Covered CA, his wife Alma, does. Diego does not qualify for APTC/CSR either because he is eligible for, and enrolled in, Medicare.

What is the new regulation's impact on Covered California?

When a family applies for coverage and one or more family members has an offer of employer coverage, Covered California must perform the following affordability determinations:

A. Employee's affordability based on the cost of self-only coverage.
B. Related individuals' affordability based on the cost of family coverage; and
C. Additional determinations for any related individuals who have an offer of coverage from another employer.

If the Employer Sponsored Coverage Net Monthly Premium for Employee + Spouse + Dependents is less than 9.12% of household income, will Spouse + Dependents still be eligible for marketplace subsidies?

No, to be eligible for marketplace subsidies, the employer sponsored coverage for the spouse and the dependents must be "unaffordable" (not meet the affordability threshold).

Does the "family premium" exclude family members who are eligible for other coverage (like Medicare or Medicaid) and thus less likely to enroll in the ESC or a QHP?

Carving out these family members would have made things a lot more complicated, since applicants would have needed to determine their dependents' eligibility for other coverage before asking their employer for their family premium. Fortunately, the regulation does not go down this road. Rather, the family premium is always based on the full tax family eligible for ESC, even if some members do not need ESC or APTC. This means consumers can begin by asking their employer for the ESC premiums for the entire tax family (and for the employee alone).

- Example: Jose and Alma Reyes are married and have two children. Jose has an annual salary of $35,000. Alma earns $10,000 from part-time work. Jose's share of the premium for his employer-sponsored health insurance is $2,500 per year to cover only him (or 5.5% of their household income). Jose's share of the premium for a family coverage through his employer to cover himself, his wife, and his children is $5,000 per year (or 11% of their household income). Since Jose and Alma's household income is under 266% FPL, their children qualify for, and are enrolled in, Medi-Cal. Jose has to still pay $5,000 per year for a family coverage to cover himself and his wife even without enrolling the children. Jose's health insurance is considered affordable for himself because it costs less than 9.12% of Jose and Alma's household income. However, Jose has to pay more than 9.12% of their household income to cover Alma under his employer's family coverage. Therefore, the employer's coverage is considered unaffordable for Alma. In that situation Jose does not qualify for APTC/CSR but his wife, Alma, does. The children do not qualify for APTC/CSR either because they are eligible for Medi-Cal. **25. Does the tax family include non-dependents who could enroll as part of the coverage unit?** No, the tax family does not include non-dependents. Potential enrollees outside the tax family are considered separately – they are not included for determining the family ESC premium, and they are not firewalled by the ESC offer.

Does the tax family include non-dependents who could enroll as part of the coverage unit?

No, the tax family does not include non-dependents. Potential enrollees outside the tax family are considered separately – they are not included for determining the family ESC premium, and they are not firewalled by the ESC offer.

Will California residents be subject to a tax penalty for not having Minimum Essential Coverage?

Yes. All California residents must have either:

- Qualifying health insurance coverage, or
- Pay a penalty when filing a state tax return, or
- Get an exemption from the requirement to have coverage.

The penalty for not having coverage the entire year will be at least $850 per adult and $425 per dependent child under 18 in the household when you file your 2022 state income tax return in 2023.

Is there a Special Enrollment Period for uninsured consumers who were impacted by the family glitch to enroll in Covered California throughout the year?

There will not be a Special Enrollment Period for the family glitch.

Will there be a calculator for consumers to use to estimate their cost of care when considering enrolling in Covered California?

Yes, we have created a downloadable PDF that consumers can use to help them gather details about their health coverage and its affordability.

Can consumers terminate their dependent coverage from their employers anytime of the year and be able to enroll in Covered California?

No. Consumers must enroll during the OEP or have a valid QLE for an SEP. Voluntary termination of an employer-sponsored coverage or termination due to nonpayment of premium is not considered "loss of coverage" qualifying life even for purposes of SEP.

How will consumers that have already signed up for employer-based coverage for their dependents be able to change their plan and enroll through Covered California?

They should ask their employer how they can remove their dependent from their employer-sponsored coverage. However, they can only enroll through Covered California during Open Enrollment or during the Special Enrollment Period with a valid QLE.

Can dependents younger than 18 years of age enroll in Covered California without an adult/parent, if the parent has affordable coverage with their employer?

Yes, the dependents under 19 can enroll in a child-only plan (including pediatric dental) through Covered California but the parent, the primary tax filer, or a responsible adult must apply for the dependents under 18 since the dependent is a minor.

Employee's dependent(s) eligible and enrolled in a Covered California plan with financial assistance may have a month in overlapped coverage from the large employer group coverage and Covered California. Will the employer be penalized since the dependent(s) received financial assistance? Or will the dependent(s) enrolled in Covered California be required to pay the premium tax credit back to the IRS for the months covered in the employer sponsored plan?

There are no penalties for the employer if the employee's dependent(s) enrolls and receives APTC/CSR through Covered California. However, the enrollee or the primary tax filer must reconcile their APTC at tax time and may have to refund some of the excess APTC to the IRS for any period of dual coverage.

Can dependents younger than 19 years of age enroll in Covered California without an adult/parent who is the employee who has affordable coverage with their employer?

Yes, an 18-year-old dependent can apply on their own and enroll in a child-only plan (including pediatric dental) through Covered California, but the primary tax filer must make certain tax filing attestations on the application.

Will the employee's dependent(s) be able to transfer their cost-sharing balance from their off-exchange plan to their Covered California plan if the insurance company and metal tier remain the same?

No, there are no coordination of benefits or transfer of cost-sharing balance between an employer-sponsored group plan and an individual plan through Covered California.

Will the dependent(s) be eligible to apply for continuity of care for their pre-existing condition with their current employer sponsored group coverage provider?

Under the continuity of care provision, a health care service plan is required to provide for the completion of covered services for certain conditions by a terminated provider or by a nonparticipating (out-of-network) provider, at the request of an enrollee who is undergoing treatment for one of those conditions at the time of the provider's termination. (Health & Safety Code, § 1373.96(a)-(b).) It does not apply when the enrollee voluntarily cancels or terminates the employer coverage.

Will there be questions on the application related to the employer sponsored plan the consumers should be prepared to answer?

Yes, they must answer questions about any offer of employer-sponsored coverage (ESC) through their own employer, if applicable, or the spouse's or parent's employer. They must also provide information about the premium cost and the coverage level for the lowest-cost ESC available to them so that Covered California can properly determine the affordability and minimum value of that ESC.

Will consumers be required to upload documentation to be eligible?

They may be required to upload identity proofing or verification documents in some circumstances.

Will employers notify their employees of the option of having dependent coverage through Covered California with financial assistance if they are income eligible? '

There are no requirements for the employers to notify the employees of the option of dependent coverage through Covered California. However, if the employee is terminating their ESC coverage, state law requires the health care service plan (in both individual and group health market) to notify the terminating enrollees that they may be eligible for reduced-cost coverage through Covered California or no-cost coverage through Medi-Cal. (Health & Safety Code, § 1366.50(a).)