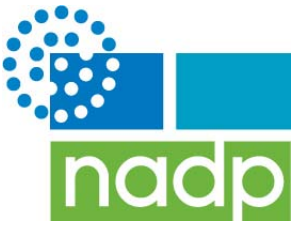

September 23, 2013

The Honorable Jack Lew, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Dear Secretary Lew:

In May, our four organizations, and others working to improve oral health care for children, wrote to you regarding the affordability of coverage for dental benefits under the Affordable Care Act. Our letter urged Treasury to apply the premium tax credit provisions of the ACA so that all pediatric dental benefits receive premium assistance just as other essential health benefits do.

We are writing today to again urge you to either 1) change your internal interpretation of the final rule on "Health Insurance Premium Tax Credit" to provide premium assistance for dental benefits regardless of how they are offered or 2) to reopen these rules to consider our input on both the policy issues relating to premium assistance for pediatric dental benefits and the legal path to revise your interpretation of policy in this area.

Our organizations and other parties with an interest in pediatric dental issues were not aware of how the Treasury Department envisioned that the section 36B credit would be calculated until after the publication of final regulations on May 23, 2012. In the preamble to the proposed regulations, the Treasury Department stated that premiums for pediatric dental coverage would be added to the premium for the benchmark plan in computing the credit. Despite this statement, in meetings with your department, we have learned that IRS plans to make premium tax credits available to support the purchase of stand-alone pediatric dental plans only in those very limited circumstances when the actual premiums for purchased coverage are lower than the premium assistance amount based on the benchmark plan in a state.

Our organizations expect that most taxpayers' premium tax credits will be calculated with reference to the cost of a "benchmark" plan—often defined as the second-lowest cost silver

plan that would cover the taxpayer's family. Based on the preamble statement and the ACA's special rule for pediatric dental coverage, we expected that benchmark would include a pediatric dental premium in the calculation whether it was included in the medical benchmark or purchased as a separate product. We anticipate that a substantial number of states will not have pediatric dental coverage in the medical benchmark, so this issue is critical to fairly provide for premium assistance for the coverage that is being purchased by consumers in those states. For example, Covered California will have no medical plans offered with pediatric dental included in 2014. New Mexico also anticipates that no medical plans will embed on their Marketplace and recently Nevada announced that no medical plan embedded dental coverage on its Exchange. As more states announce coverage and rates, others will join this list and your decision will impact millions.

As we stated in our previous letter, the Affordable Care Act allows the costs for stand-alone dental coverage to be included in the cost of benchmark coverage. Internal Revenue Code section 36B, paragraph (b)(3)(E), provides that "For purposes of determining the amount of any monthly premium," a premium paid for a separately offered EHB dental benefit should be considered a premium payable for a qualified health plan. The law's reference to "any" monthly premium must be interpreted to apply to the benchmark plan premium that determines a taxpayer's premium credit amount. Without such a reading, some families would be required to pay more than their applicable percentage of income to purchase coverage for all the EHBs—this is not what Congress intended.

Oral health is critical to children's overall wellbeing. Congress recognized as much when it included oral care for children as one of the essential health benefits specified in the ACA. Congress also intended that the purchase of the entire essential health benefits package be supported with premium tax credits. In a 2011 Senate colloquy, three Senators who were key to the inclusion of pediatric dental benefits as an essential health benefit and the ability of stand-alone dental plans to provide that coverage clarified that the law intends that "children receiving coverage through an Exchange would have the same level of benefits and consumer protections, including all cost sharing and affordability protections, with respect to oral care. This holds true whether they received pediatric oral care coverage from a stand-alone dental plan or from a qualified health plan."[i]

Adding the cost of the pediatric dental coverage in a separate dental policy would raise the premium assistance amount for many families, allowing them to afford dental care for their children. Given the HHS determination that pediatric dental coverage is a required offer rather than a required purchase inside Exchanges, this premium assistance is even more critical to families obtaining needed coverage. It can, in fact, act as an incentive to purchase coverage.

Without premium credits for separate dental policies, many families will be tempted to forego dental coverage for their children. This would be an enormous missed opportunity to provide oral health services to vulnerable children who need them and circumvent Congressional intent that pediatric dental benefits be included in the essential benefits that Exchange enrollees will receive.

Treasury has an important role to play in supporting children's health by assuring that premium credits are applied as intended by the Affordable Care Act. Our organizations offer the attached legal memo providing support to interpret the ACA to provide premium assistance for pediatric dental for all consumers. We are happy to meet further with your staff to provide additional insight on this issue. Thank you for your consideration.

Sincerely,

Kathleen O'Loughlin
Executive Director
American Dental Association

Patrice Pascual, MA
Executive Director
Children's Dental Health Project

Steven R. Olson
President & CEO
Delta Dental Plans Association

Evelyn F. Ireland, CAE
Executive Director
National Association of Dental Plans

[i] Senator Stabenow (MI). "Affordable Care Act." Congressional Record 157: 144 (September 26, 2011).

MEMORANDUM

Hogan Lovells US LLP
Columbia Square
555 Thirteenth Street, NW
Washington, DC 20004
T +1 202 637 5600
F +1 202 637 5910
www.hoganlovells.com

TO National Association of Dental Plans

FROM Kurt L.P. Lawson **TELEPHONE** +1 202 637 5660

DATE September 5, 2013

SUBJECT Inclusion of Cost of Pediatric Dental Coverage in Benchmark Plan under Section 36B

Issue

You asked whether the Treasury Department has the authority to adopt a rule analogous to section 1.36B-3(f)(3) of the Treasury Regulations (the "family coverage rule") in situations where one or more silver-level plans offered through an Exchange do not include the pediatric dental coverage element of the essential health benefits package that qualified health plans must provide under section 1302 of the Affordable Care Act (the "ACA").

The family coverage rule provides that if one or more silver-level plans for family coverage offered through an Exchange do not cover all members of a taxpayer's family under one policy, the premium for the "applicable benchmark plan" under section 36B(b)[1] may be the premium for a single "qualified health plan" that covers all members of the taxpayer's family or the premiums for more than one "qualified health plan," whichever is the second lowest cost silver option.

The analogous rule would provide that, if at least one silver-level plan offered through an Exchange does not include pediatric dental coverage, the premium for the "applicable benchmark plan" under section 36B(b) may be either the premium for a single "qualified health plan" that includes pediatric dental coverage, or the premium for a "qualified health plan" that does not include pediatric dental coverage plus the premium for pediatric dental coverage under a plan described in section 1311(d)(2)(B)(ii) of the ACA (a "stand-alone dental plan") offered on the same Exchange, whichever is the second lowest cost silver option.

As explained below, the Treasury Department has the authority to adopt a rule analogous to the family coverage rule in situations where one or more silver-level plans offered through an Exchange do not include pediatric dental coverage.

---

[1] Unless otherwise indicated, all references to sections are references to sections of the Internal Revenue Code of 1986 (the "Code").

Analysis

1. Authority Based on General Rule in Section 36B(b)(2)

Section 36B(b)(2) defines the "premium assistance" amount for a month as the lesser of (i) the premiums for the month for the "qualified health plans" actually purchased on the Exchange[2] for the taxpayer and the taxpayer's spouse and dependents, or (ii) the excess of (a) the "adjusted monthly premium" for the month for the "applicable second lowest cost silver plan" with respect to the taxpayer, i.e., the "applicable benchmark plan," over (b) a sliding-scale percentage of the taxpayer's household income for the month.

Section 36B(b)(3)(B) defines the "applicable second lowest cost silver plan" as the "second lowest cost silver plan" in the taxpayer's rating area that is offered on the Exchange and that (i) "provides . . . self-only coverage" in the case of a taxpayer who either has no spouse or dependents or purchases self-only coverage, or (ii) "provides . . . family coverage" in the case of any other taxpayer.

In adopting the family coverage rule, the Treasury Department properly interpreted the definition of "second lowest cost silver plan" in the statute to include more than one plan in situations where some qualified health plans offered through an Exchange might exclude certain tax dependents (for example, a niece). It explained that this was consistent with the fact that "[s]ection 36B determines family size by reference to individuals for whom the taxpayer claims a personal exemption."[3] Without this interpretation, the "coverage" that the statute requires the second lowest cost silver plan to "provide" would not match the family members that section 36B is intended to benefit, and whose incomes are taken in to account in determining the maximum amount of the credit; and taxpayers would not be encouraged, and in some cases would not even be able, to purchase coverage for the family members they are required to cover under section 5000A of the ACA.

The Treasury Department could do the same thing in situations where some qualified health plans offered through an Exchange do not include pediatric dental coverage. All that would be required would be for it to interpret the term "silver plan" in section 36B(b)(3)(B) to include multiple policies if a single policy might not suffice to carry out the purposes of that section, as it already did under the family coverage rule.

---

[2] The statute adds that the Exchange is one "established by the State under [section] 1311 of the [ACA]." Section 1.36B-1(k) of the Treasury Regulations interprets this, by cross-reference to section 155.20 of the Department of Health and Human Services regulations (the "HHS Regulations"), to include a Federally-facilitated Exchange established pursuant to section 1321 of the ACA. According to testimony by Deputy Assistant Secretary for Tax Policy Emily S. McMahon on July 31, 2013, "Treasury and IRS believe that" this interpretation of the statutory language "is appropriate to its context and consistent with the purpose and structure of the statute as a whole, pursuant to longstanding and well-established principles of statutory construction."

[3] *See* 76 Fed. Reg. 50931, 50937 (Aug. 17, 2011).

A "plan" in this context means a qualified health plan.[4] That is not an obstacle to this interpretation because the HHS Regulations already treat a stand-alone dental plan offered on an Exchange as "a type of qualified health plan" as defined in section 1301 of the ACA, and require it to meet all of the qualified health plan certification requirements except those that cannot be met because it covers only dental benefits.[5] Such a plan also must be a silver plan. That, too, is not an obstacle because, while stand-alone dental plans offered on an Exchange are not required to provide specific metal levels of coverage in the same way as major-medical plans are, they are subject to a very closely analogous rule.[6] The Treasury Department could, for example, treat a stand-alone dental plan that provides a "low" level of coverage under that rule as equivalent to a silver-level plan. Section 36B(b)(2) also refers to a "plan" in the singular. However, that should not be an obstacle because the term "plan" easily encompasses coverage provided under more than one policy or contract of insurance.[7]

The Treasury Department could, further, limit the scope of this rule to situations where an individual either enrolls in a "qualified health plan" that provides pediatric dental coverage or enrolls in both a "qualified health plan" and a stand-alone dental plan that provides pediatric dental coverage. That would help align the premium assistance amount with the cost of the coverage that's actually being purchased, similar to the rules in section 36B(b)(3)(B)(ii)(I)(bb) (taxpayer with family who purchases self-only coverage) and (b)(3)(E) (individual who enrolls in both qualified health plan and stand-alone dental plan), and affirmatively encourage taxpayers to purchase pediatric dental coverage for their children.

Without this interpretation:

- The "coverage" that section 36B(b)(3)(B)(ii) requires the second lowest cost silver plan to "provide" would not match the package of essential health benefits that the ACA requires issuers to make available on an Exchange, which the drafters of the ACA considered so essential that they extended the requirement to insurance policies offered in the individual and small group market outside of an Exchange;

- Taxpayers would not be encouraged, and in some cases would not even be able, to purchase pediatric dental coverage for their children; and

---

[4] *See* ACA § 1302(d)(4) ("In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.").

[5] *See* 45 C.F.R. § 155.1065(a)(3) and 77 Fed. Reg. 18310, 18315 (March 27, 2012); *cf.* 26 C.F.R. § 1.36B-1(c) ("The term qualified health plan has the same meaning as in section 1301(a) of the Affordable Care Act.").

[6] *See* 45 C.F.R. § 156.150(b)(2).

[7] *See* ACA § 1301(a)(1) ("The term 'qualified health plan' means a health plan [that satisfies certain specified requirements].") and (b)(1)(A) ("The term 'health plan' means health insurance coverage and a group health plan."); Public Health Service Act § 2791(b)(1) ("health insurance coverage" means "benefits consisting of medical care . . . under *any* hospital or medical service policy or certificate" (emphasis added)); *Ali v. Federal Bureau of Prisons*, 552 U.S. 214, 218-19 (2008) ("any" has an expansive meaning, that is, "one or some indiscriminately of whatever kind" (citations omitted)); *Teles AG v. Kappos*, 846 F. Supp.2d 102, 112 (D.D.C. 2012) ("any" is generally used in the sense of "all" or "every" and its meaning is "most comprehensive" (citations omitted)); *cf.* 26 C.F.R. § 54.9801-4(c)(2) (rule for plans that provide creditable coverage through one or more policies or contracts of insurance).

- The regulations on advance payments of the credit under section 1412 of the ACA, which require an allocation of the credit between plans purchased on an Exchange that do not include pediatric dental coverage and stand-alone dental plans that do,[8] would makes little sense where the premium assistance amount could easily disregard the cost of purchasing pediatric dental coverage on that Exchange.

2. Authority Based on the Special Rule for Pediatric Dental Coverage in Section 36B(b)(3)(E)

Section 36B(b)(3)(E) provides that "[f]or purposes of determining the amount of any monthly premium," if an individual enrolls in both a qualified health plan and a stand-alone dental plan, the portion of the premium for the stand-alone dental plan that is allocable to the pediatric dental coverage element of the essential health benefits package "shall be treated as a premium payable for a qualified health plan."

We understand that the Treasury Department and Internal Revenue Service currently interpret this special rule to apply only to the first prong of the rule for determining the premium assistance amount, in section 36B(b)(2)(A), and not to the section prong in section 36B(b)(2)(B).[9]

This limited interpretation is not necessarily required by the statutory language. The Treasury Department could interpret the special rule more broadly to create a rule analogous to the family coverage rule. Section 36B(b)(3)(E) states that the special rule applies "[f]or purposes of determining the amount of *any* monthly premium" (emphasis added). The Treasury Department could interpret this to refer to the monthly premium for the applicable second lowest cost silver plan (*i.e.*, the benchmark plan) referenced in section 36B(b)(2)(B). The premium must be for a "qualified health plan," but, as noted above, the HHS Regulations already treat a stand-alone dental plan offered on an Exchange as "a type of qualified health plan" and require it to meet most of the qualified health plan certification requirements. If the Treasury Department considered it appropriate, it also could limit the scope of this rule to situations where the stand-alone dental plan in which the individual enrolls provides a "high" level of coverage or is otherwise analogous to a silver-level plan.

We understand that the Treasury Department and Internal Revenue Service might be concerned that the separate references to "the monthly premium or the adjusted monthly premium" in the same sentence in section 36B(b)(3)(D) suggest that the phrase "monthly premium" in section 36B(b)(3)(E) refers only to "the monthly premium" in section 36B(b)(2)(A) and not to "the adjusted monthly premium" in section 36B(b)(2)(B). However, such an interpretation is not required: an "adjusted monthly premium" clearly is *a* "monthly premium," and the reference in section 36B(b)(3)(E) is to "*any* monthly premium" (emphasis added) not "*the* monthly premium" (emphasis added) as in section 36B(b)(3)(D). As the Supreme Court has explained, when interpreting a statute "any" has an expansive meaning, that is, "one or some indiscriminately of whatever kind."[10]

[8] *See* 45 C.F.R. § 155.340(e) and (f).

[9] *See also* 26 C.F.R. § 1.36B-3(k)(3).

[10] *See Ali*, *supra* note 7.

This interpretation appears to have been contemplated by the Treasury Department when it developed the proposed regulations: The preamble to the proposed regulations states that, when the special rule for pediatric dental coverage in section 36B(b)(3)(E) is triggered, "the portion of the premium for the separate pediatric dental coverage is added to the premium for the *benchmark plan* in computing the credit" (emphasis added).[11]

The only difference between this interpretation of the special rule in section 36B(b)(3)(E) and the interpretation of the general rules in section 36B(b) described above is that the premiums that are taken into account are based on the plan actually purchased by the individual rather than a benchmark plan in the individual's rating area.

3. Need to Re-Open Comment Period

The National Association of Dental Plans ("NADP") and other parties with an interest in pediatric dental issues were not made aware of how the Treasury Department envisioned that the section 36B credit would be calculated until after the publication of final regulations on May 23, 2012. As noted above, the preamble to the proposed regulations stated that premiums for pediatric dental coverage would be added to the premium for the *benchmark plan* in computing the credit.[12] Moreover, it was not clear until after the end of the comment period that individuals would even be *allowed* to purchase coverage on an Exchange that did not include the pediatric dental coverage element of the essential health benefits package.[13] Thus, NADP and others were not put on notice of the significance of the interpretive issue discussed above in time to comment effectively on it.

The Administrative Procedure Act demands that when an agency engages in rulemaking, it publish a notice that includes "either the terms or substance of the proposed rule or a description of the subjects and issues involved."[14] The notice must be sufficiently detailed for interested parties to "know what to comment on."[15] Under the circumstances it therefore is appropriate for the Treasury Department to accept and consider new comments on this issue.

Conclusion

Section 36B(g) gives the Treasury Department broad authority to "prescribe such regulations as may be necessary to carry out the provisions of this section." It is within the scope of that authority to adopt a rule analogous to the family coverage rule in situations where one or more silver-level plans offered through an Exchange do not include the pediatric dental coverage, based either on the general rules in section 36B(b) or the special rule in section 36B(b)(3)(E).

---

[11] *See* 76 Fed. Reg. 50931, 50937 (Aug. 17, 2011).

[12] The proposed regulations also stated that the exact portion of the premium for a stand-alone dental plan that was properly allocable to pediatric dental benefits would be determined under yet-to-be-issued guidance provided by HHS. *See* Proposed 26 C.F.R. § 1.36B-3(k)(2).

[13] *See* 78 Fed. Reg. 12833, 12853 (Feb. 25, 2013) (stating that "nothing in this rule requires the purchase of the full set of EHB if the purchase is made through an Exchange. Thus, in an Exchange, someone (with a child or without) can purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan.").

[14] *See* 5 U.S.C. § 553(b)(3).

[15] *See Owner-Operator Indep. Drivers Assoc. v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 209 (D.C. Cir. 1997); *see also CSX Transp., Inc. v. Surface Transp. Bd.*, 584 F.3d 1076, 1081 (D.C. Cir. 2009).

Although the period for commenting on the proposed regulations under section 36B that were published in 2011 is now closed, because the proposed regulations did not provide adequate notice that the final regulations might not include the cost of pediatric dental coverage in the cost of the applicable benchmark plan under all circumstances it is appropriate for the Treasury Department to re-open the comment period with respect to this issue.

Kurt L.P. Lawson
Partner
kurt.lawson@hoganlovells.com