



December 6, 2013

Mr. Peter Lee, Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814
Sent via Email: info@hbex.ca.gov

RE: **Dental Policy Recommendation for Covered California in 2015**

Dear Mr. Lee;

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the structure and offer of pediatric dental benefits on the Covered California Marketplace. This issue is critical for California residents to have choice and access to quality, affordable oral health care.

BACKGROUND

The U.S. Congress was very clear on the importance and role of oral health and dental benefits within the Patient Protection and Affordable Care Act (ACA). Pediatric dental is identified as one of the 10 essential health benefits¹ and that stand-alone dental plans have the ability to offer policies on newly established Marketplaces².

A critical component of the Marketplaces is Advance Premium Tax Credits (APTC), which provide Americans who qualify, with subsidies to assist in covering health and dental premiums. Within current IRS calculations, the dental portion of tax subsidies is not always included in the overall equation for enrollees, which means many Californians may not receive the full amount of tax credits available. (NADP's Issue Brief on this issue is attached.)

Covered California has also been discussing whether pediatric dental should be a required purchase by enrollees. A required purchase of pediatric dental for children has been required in Kentucky, Nevada, and Washington³.

¹ ACA Section 1302(b)(1)(J).

² ACA Section 1311(d)(2)(B)(ii) "each Exchange within a State shall allow an issuer of a plan that provides only limited scope dental benefits... to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits..."

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"the representative and recognized resource of the dental benefits industry"



RECOMMENDATION

How to develop a legal, vibrant and competitive medical and dental marketplace within Covered California, while ensuring Californians receive all the tax credits to which they are entitled, has been debated over the last few months. The California Association of Dental Plans (CADP), which NADP works with, has a solution:

- Allow all policy types, including a medical policy with embedded pediatric dental (10), medical policies without pediatric dental (9.5), and separate dental policies (.5) to offer coverage on Covered California to meet ACA's legal requirements. This arrangement is also how 47 other state Marketplaces are allowing dental benefits to be offered⁴. To ensure the full APTC is applied, Covered California can utilize its status as an active purchaser to work with carriers to guarantee the 2nd lowest silver plan is a 10 policy.

Further, if Covered California should require the purchase of pediatric dental for children, this is a simple technical correction within the CalHEERS website and NADP would encourage Covered California to work with Kentucky, Nevada and Washington Exchanges to learn more about how their systems are complying with a similar state requirement, as HHS Exchange grants encouraged the sharing of this type of information among states.

The procedure of confirming the 2nd lowest silver policy is a medical policy with embedded pediatric dental must be transparent to carriers when applying to be on the Marketplace. It will become part of the negotiation process Covered California currently utilizes to negotiate rates with carriers. As outlined, the recommendation from the industry ensures that Covered California aligns with the ACA and ensures enrollees competitive choices which parallel the typical employer market.

WAKELY REPORT

In November, Covered California released a report it commissioned from the Wakely Consulting Group on the inclusion of pediatric dental within the new Marketplace. The report offers recommendations based on actuarial data, pricing and background information but did not include legal review or guidance.

Covered California has recommended to its Board and subcommittees one of the options outlined in the Wakely Report in which the Marketplace would only offer medical policies with embedded pediatric dental (10) and separate stand-alone dental policies (.5). This would mean that policies offered by stand-alone dental plans would be duplicative of what is offered by the medical carrier and that medical plans do not have the option of offering a 9.5 plan. When a board member asked the legal question as where the 9.5 requirement comes into play, the response was to request a waiver from HHS and push those plans to the side (or hide them.) This recommendation goes entirely against what is stated clearly in the ACA and is an inappropriate attempt to bypass legal requirements.

³ CT is not able to offer separate dental policies in 2014 and therefore, their medical policies must embed pediatric dental which by default makes it a required purchase by their enrollees.

⁴ WA and CA are states in which there are 9.5 and .5 plans offered, while CT received a waiver to not offer .5 plans for only 2014 due to technical issues.

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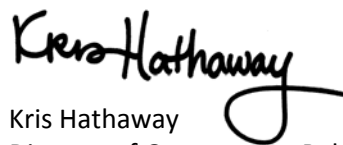
In addition, a 10 and .5 policy recommendation requires a change and disruption to 2014 policy holders and severely limits enrollee choice. Understandably, enrollees will choose their medical policy first and thus by default will have to use the dental benefit that is included in that policy. They will not have the option to shop for a dental plan which includes their dentist or has the best selection of benefits for them. To further suggest the purchase of an additional .5 policy in order to keep their dentist is burdensome, costly and not in the best interests of the consumer.

The U.S. Senate, including Senator Boxer and Senator Feinstein, oral health stakeholders, NADP, and others continue to advocate for the clarification of tax credits to the IRS (letters attached.) While we have heard there are no policy objections, it has not become a priority of the IRS to resolve to date. NADP encourages Covered California and all interested stakeholders to contact the IRS and join in this effort.

We are greatly appreciative for Covered California's attention to the oral health of young Californian's, and reaching out to stakeholders to better understand the complex issues surrounding dental benefits within the ACA. When Covered California met with CADP and their members they requested alternatives, and we hope that you will carefully consider our proposed recommendation.

Thank you for your attention to our letter, and if you have any questions related to this letter or how dental is being incorporated in other states, please feel free to contact me directly at 972.458.6998x111 or khathaway@nadp.org.

Sincerely,



Kris Hathaway
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DENTAL & TAX CREDITS WITHIN THE ACA

BACKGROUND: The ACA requires tax credits, also known as premium assistance, to be available for lower income individuals purchasing health coverage on individual Exchanges. The assistance can be used to pay premiums for a consumer's health benefits --both medical and pediatric dental.

The ACA specifically provides for pediatric dental coverage to be offered separately from medical coverage in Exchanges to parallel today's insurance market. Under the ACA and IRS rules, premium assistance that a consumer receives is the lesser of:

- 1) the premium they will pay for the coverage purchased through an Exchange, or
- 2) the excess of the state's benchmark plan's (2nd lowest silver) premium over the maximum percentage of the consumer's household income to be paid in premium¹.

The ACA included a special rule to include the premium for pediatric dental in the calculation of premium assistance. IRS rules on Health Insurance Premium Tax Credits apply this special rule only to option 1 of the calculation of premium assistance outlined above. In other words, if a consumer purchases a medical policy without dental and a separate dental policy AND the combined premiums are less than the calculated premium assistance based on the benchmark plan, then pediatric dental is specifically included in the tax credit.

Most tax credits are expected to be calculated based on the 2nd option above, i.e. the 2nd lowest cost silver plan. In most Exchanges, the 2nd lowest cost silver plan will be a medical policy without dental. IRS plans to use only the medical premium for premium assistance calculations under option 2 above. Therefore, in states where the 2nd lowest medical plan does not include pediatric dental, no consumer will receive premium assistance for their pediatric dental benefits. In other states where the 2nd lowest silver plan includes pediatric dental, all consumers will receive premium assistance for dental, whether they purchase health benefits with pediatric dental or not.

Because the Federally-facilitated Marketplace and many state-based Exchanges have determined that stand-alone pediatric dental is a required *offer* not a required *purchase*, without premium assistance consumers may not purchase critical pediatric dental coverage for their children as Congress intended.

RECOMMENDATION: IRS should calculate tax credits based on all 10 essential benefits—whether contained in 2 policies or one for consumers in all states to be treated equally with regard to premium assistance. Further the IRS should segregate a portion of the tax credit to be utilized only when pediatric dental is purchased, as intended by Congress. In each state, the IRS should note:

1. The total subsidy is available for a medical policy covering all 10 essential benefits;
2. A portion² of the subsidy is reserved for the purchase of pediatric dental under a stand-alone dental plan in addition to a medical policy without a pediatric dental benefit.

VALUE: By improving the affordability of pediatric dental benefits, more families are likely to enroll and seek critical preventive pediatric dental care.

¹ 26 CFR 1.36B-3(f)(3); pg. 30391

² Dental benefits average about 1/12th of the annual premium of a medical policy. So if a medical policy costs \$12,000 annually, the corresponding dental policy for a family would be about \$1000. Since only the child portion of a family dental policy is being supported by tax credits, an allocation of 5%-6% of the tax credit for the purchase of pediatric dental coverage would be reasonable.

United States Senate

WASHINGTON, DC 20510

September 24, 2013

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

Dear Secretary Lew,

We thank you for your critical work implementing the Affordable Care Act, including the premium tax credits that will help families across the country choose a health insurance plan that fits their budget through the new insurance marketplaces. As you continue working to implement the premium tax credits going forward, we urge you to clarify that the value of the credit takes into account pediatric dental benefits, even in states in which those benefits are offered through stand-alone plans.

One of the primary goals of the Affordable Care Act is to ensure that every family is able to afford the care they need, especially for children. This includes pediatric dental benefits. It is critical that the premium tax credits that will help families afford comprehensive health insurance account for the cost of pediatric dental benefits in all cases. Without premium credits that can assist with the purchase of stand-alone dental plans, some families may be forced to forgo pediatric dental coverage.

Congress intended for these premium tax credits to be based on plans that take into account all 10 essential benefits (EHB), including pediatric dental benefits whether purchased as an “embedded” part of a medical plan or in a separate, “stand alone” dental policy. Section 1401 of the ACA reflects this intent with the addition of 36B (b)(3)(E) to the Internal Revenue Code that requires pediatric dental premiums for stand-alone dental plans to be treated as part of the qualified health plan premium for calculating the premium tax credit.

The final rule on the Health Insurance Premium Tax Credit provides in part for the calculation of the premium tax credits in the new health insurance marketplaces with reference to the cost of a “benchmark” plan defined in the statute as the second-lowest cost 70% actuarial value silver plan. As noted, the statute, and to an extent, the rule also requires that premiums paid for pediatric dental benefits from stand-alone dental plans be treated as premium for that plan where an individual enrolls in both a qualified health plan and a stand-alone dental plan.

In many states, however, the benchmark plan used to calculate these credits will not provide coverage for pediatric dental benefits even though they are an EHB. In those states, pediatric dental benefits will be offered by a stand-alone dental plan, but consumers would receive a lower credit that would not account for the costs of purchasing a stand-alone pediatric dental plan, thereby decreasing their affordability for families.

It is important to make clear that the premium tax credit includes pediatric dental in all methods of calculating the assistance to ensure that individuals and families have the same basic affordable coverage options available in every state. We urge you to use your rulemaking authority going forward to clarify that the premium tax credit is calculated with reference to plans that reflect the full range of essential health benefits including pediatric dental benefits provided through a stand-alone plan where an individual enrolls in both a qualified health plan and a stand-alone dental plan.

This can be accomplished by calculating the credits in a manner that takes into account the pediatric portion of the premium for the second-lowest cost 70% actuarial value stand-alone dental plan in states in which the benchmark silver plan does not include pediatric dental benefits. It would also need to be made clear that the full credit amount that includes the cost of the stand-alone pediatric dental benefit should only be available when pediatric dental benefits are purchased, whether as a stand-alone plan, or an embedded benefit.

We thank you again for your efforts implementing the premium tax credits in the Affordable Care Act, and look forward to working with you to ensure that they are applied consistent with the statute to all essential health benefits including pediatric dental benefits and are distributed on an equitable basis to families across all the states.

Sincerely,

Rebbie Staversow

Walt

May of Gordon

Shirley Brown

Mark Udall

Al Franken

Dianne Feinstein

Barack Obama

Ben Sanders

Bob Casey, Jr.

Mark F. B. A

Kirsten E. Gillibrand

Mark R. Warner

Jeffrey A. Merkley



September 26, 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.

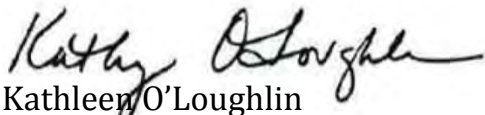
Oral health is critical to children's overall wellbeing. Congress recognized as much when it included oral care for children as one of the essential health benefits specified in the ACA. Congress also intended that the purchase of the entire essential health benefits package be supported with premium 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.

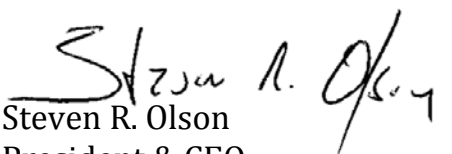
Without premium credits for separate dental policies, many families will be tempted to forego dental coverage for their children. This would be an enormous missed opportunity to provide oral health services to vulnerable children who need them and circumvent Congressional intent that pediatric dental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

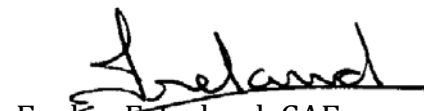
Treasury has an important role to play in supporting children's health by assuring that premium credits are applied as intended by the Affordable Care Act. Our organizations offer the attached legal memo providing support to interpret the ACA to provide premium assistance for pediatric dental for all 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

Cc: Mark J. Mazur, Assistant Secretary for Tax Policy, U.S. Department of the Treasury

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William J. Wilkins, Chief Counsel, Internal Revenue Service

Erik H. Corwin, Deputy Chief Counsel (Technical), Internal Revenue Service

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



MEMORANDUM

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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 Exchange² 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 make 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.

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