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Research Brief

Health Insurance Marketplaces Offer a Variety of Dental Benefit Options, but Information Availability is an Issue

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Key Messages

- *There is considerable variation across states in how dental benefits are offered within the newly established health insurance marketplaces. In some marketplaces, pediatric dental benefits can be purchased only through stand-alone dental plans, while in others all medical plans include embedded pediatric dental benefits.*
- *There is limited information available to consumers on many key attributes of dental plans within the marketplaces, making it challenging to make meaningful comparisons and fully informed decisions.*
- *Stand-alone dental plans and medical plans with embedded dental benefits differ in several ways, including out-of-network coverage, deductible arrangements, and premiums.*
- *Further research is needed to study the implications of alternative marketplace set ups on consumer purchasing decisions and, ultimately, access to dental care.*

Introduction

The Affordable Care Act (ACA) will extend health insurance to millions of Americans. Recognizing the importance of oral health, pediatric dental services are one of the ten essential health benefits that all small group and individual market health plans are required to cover.[1] Early estimates predict that almost 9 million children could gain dental benefits coverage due to the ACA, with 3 million gaining such coverage through health insurance marketplaces (hereinafter referred to as marketplaces).[2] Dental benefits for adults, however, are not an essential health benefit under the ACA. Health plans may still offer adult dental coverage, but they are not required to do so. Therefore, the estimated number of adults potentially gaining private dental benefits through the marketplaces is much smaller.[3]

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Based on the interpretation of the pediatric dental services mandate, health plans sold through the marketplaces are actually not required to include pediatric dental benefits as long as there are stand-alone dental plans (SADPs) available for purchase.[4] Further, all SADPs offered through the marketplaces must include pediatric dental benefits.[5] Thus, the marketplaces can offer pediatric dental benefits in one of three ways: (1) through an SADP, (2) through a dental plan bundled with a medical plan, and (3) through a medical plan that has embedded pediatric dental benefits.[6] As there are no bundled dental plans offered through the marketplaces for 2014,[7] individuals currently have at most two methods of obtaining pediatric dental coverage.[8]

Individuals have until March 31, 2014 to enroll in a health plan to meet the ACA's individual mandate requirement[9] after which they are subject to tax penalties.[10] While pediatric dental benefits are "essential" under the ACA, consumers will not be penalized if they fail to purchase dental benefits for their child.[11] Allowing marketplaces to offer SADPs essentially disconnected pediatric dental benefits from the tax penalty, and consumers are not actually required to purchase them.[12]

Premium subsidies are also complex when it comes to dental benefits. To help offset the cost of purchasing health insurance, the ACA established premium assistance for certain income groups in the form of tax credits for plans purchased through the marketplaces.[13] How premium assistance applies to SADPs, however, is not straightforward. Individuals can technically apply their premium tax credits toward pediatric SADP premiums, but it is unlikely that the tax credit will be large enough to offset any of the cost of the pediatric SADP.[14] Additionally, adult dental coverage purchased through an SADP is not subject to premium assistance because it is not considered essential under the ACA.[15]

As a result of the absence of a true requirement to purchase pediatric dental benefits under the ACA, the structure of a state's marketplace plays a crucial role in the expansion of dental benefits coverage for children. Specifically, the purchase of pediatric dental benefits is only guaranteed if a state either (1) only offers medical plans that embed or bundle pediatric dental benefits, or (2) requires consumers that purchase pediatric medical benefits to also purchase pediatric dental benefits. To date, only Kentucky, Nevada and Washington require consumers to purchase pediatric dental benefits.[16]

With so much variability, a critical overarching policy question is, to what extent will the establishment of health insurance marketplaces increase access to dental care for children in the United States? This ultimately depends on how effective the marketplaces are at expanding dental benefits coverage for children, and how effectively this expansion of coverage increases access to dental care. These issues warrant significant research effort. A first step is simply to understand how pediatric dental benefits are actually being offered within the marketplaces, and this is the focus of our analysis.

In this research brief, we analyze key attributes of all medical plans and SADPs offered through both the federally-facilitated marketplace (FFM) and select state-based marketplaces (SBMs) focusing primarily on pediatric dental benefits. We assess the level of information that is available to consumers when shopping for dental benefits within the marketplaces. We categorize states according to how dental benefits are offered in their marketplace. We compare key attributes of medical plans that have embedded dental benefits to SADPs. We conclude with a discussion of the policy implications of our findings.

Data & Methods

In 2014, 34 states are participating in the FFM, and the remaining 17 states (including the District of Columbia) have established SBMs (see Table 1).[17]

Federally Facilitated Marketplace Analysis

We analyzed medical plan and SADP information for individuals and families from the Centers for Medicare and Medicaid Services' (CMS) website healthcare.gov. We downloaded data for all plans available in the 34 states participating in the FFM, as well as data for plans in 2 states that are temporarily operating through the FFM until their SBMs are ready (see Table 1).[18,19,20,21] The data used in this analysis were downloaded on January 13, 2014.[22,23]

The data available through the FFM list every medical plan and SADP offered by rating area.[24] We used the variable "Plan ID – Standard Component" (Plan ID) as the unique plan identifier and counted each Plan ID as a unique observation. We summarized the number of medical plans and SADPs offered, the number of medical plans with embedded dental benefits, the actuarial value of plans, and the average pediatric premiums for medical plans with and without embedded dental benefits and for SADPs.[25]

State-Based Marketplace Analysis

We visited the 15 SBM websites between December 2, 2013 and January 6, 2014.[26,27,28,29,30,31,32,33,34,35,36,37,38,39,40] Five SBM websites provided robust data on the medical plans and SADPs available for purchase, and these states were included in our analysis (see Table 1).[41,42,43,44,45] The remaining ten SBM websites either provided less robust information, or required individuals to create an account to preview medical plan and SADP information.[46] These states were not included in our analysis (Table 1).

For the five states included in our analysis, we summarize the number of medical plans and SADPs available for purchase, the number of medical plans with embedded dental benefits, the actuarial value of plans, and the average child premiums for SADPs. Where we were not able to collect reliable premium information within a SBM, we omitted that state from the analysis of premiums.

In-Depth Analysis of Pediatric Dental Benefits within a Sample of Plans

We carried out a more detailed analysis on a sample of plans. Using data from the 36 states on the FFM, we randomly selected 50 medical plans with embedded pediatric dental benefits (sample created January 14, 2014) and 50 SADPs (sample created January 23, 2014). We then analyzed each plan's Statement of Benefits and Coverage (SBC). The SBCs were found using the links provided by CMS on the healthcare.gov website. We collected information on key plan attributes including deductibles, services covered, coinsurance levels, and dental provider networks. In general, the SBCs for SADPs provided most of this information. However, information on dental benefits within the SBCs of medical plans that include embedded dental benefits was more limited. In these cases, we conducted additional web-based research to collect missing information (between January 14 and 27, 2014). If information was still not available, we then conducted telephone calls to the individual insurance company offering the plan (between January 16 and 28, 2014).

We analyzed medical plans and SADPs by actuarial value. The actuarial value is the percentage of the total average costs that a plan will pay for the benefits it covers.[47] There are four medical plan actuarial values: platinum, gold, silver and bronze.[48] The percentage of

costs that a plan pays ranges from 60% (bronze) to 90% (platinum). Some consumers may also be eligible to purchase a catastrophic plan. Only three primary care visits are paid for by catastrophic plans; all other services must be paid for by the consumer until the deductible is met.[49] There are two SADP actuarial values. High actuarial value plans pay 85% of average costs, and low actuarial value plans pay 70% of costs.[50]

Results

Figure 1 summarizes the breakdown of how dental benefits are being offered in the marketplaces. Within the 41 states we analyzed, there were a total of 3,180 medical plans and 697 SADPs being offered. The number of medical plans offered by each state ranges from 11 in New Hampshire to 257 in Wisconsin. The number of SADPs offered by each state ranges from two in Vermont to 51 in Michigan.

Looking across all medical plans, 26% have embedded pediatric-only dental benefits. Another 0.7% of medical plans have embedded pediatric and adult (i.e. family) dental benefits. Only 0.4% of medical plans have embedded adult-only dental benefits, and all of these plans are offered in Ohio. Looking across all SADPs, 42% offer pediatric-only dental benefits, and 58% offer family dental benefits. Family SADPs can be purchased for children only, adults only, or a mix of children and adults. In accordance with the ACA, none of the SADPs offer adult-only dental benefits.[51]

Table 2 demonstrates that there is considerable variation across states in how pediatric dental benefits are being offered. In seven states, none of the medical plans offered have an embedded pediatric dental benefit. On the opposite end of the spectrum, there are two states where every medical plan has an embedded pediatric dental benefit. SADPs are offered in every state we analyzed.

While none of the states we reviewed mandate that medical plans have embedded pediatric dental benefits, some states chose to not allow medical plans to include embedded pediatric dental benefits. For example, for 2014, the board governing California's marketplace decided not to allow medical plans to embed pediatric dental benefits.[52] This policy decision has been reversed for 2015.[53]

Figure 2 summarizes the breakdown of medical plans and SADPs by their actuarial value,[54] or the percentage of an enrollee's costs that a plan will typically pay. Silver, with an actuarial value of 70% is the most common type of medical plan being offered across the marketplaces. There is some state-level variation in the breakdown of actuarial value of plans offered, with silver making up only 22.5% of the plans offered in Arkansas, compared to 38.1% of the plans offered in Tennessee. There is no significant difference in the actuarial value breakdown of medical plans with and without embedded dental benefits (results not shown).

Just over half of SADPs are low actuarial value. Similar to medical plans, there is some state-level variation. In Arkansas, for example, 44% of offered SADPs are low actuarial value compared to 100% of the SADPs offered in Washington. The actuarial value breakdown of pediatric-only and family SADPs mirrors the overall breakdown (results not shown).

Table 3 summarizes the dental benefits information available to consumers when they shop the marketplaces for plans. As noted in the methods section, this analysis is at the plan level and is based on a random sample of 50 medical plans with embedded pediatric dental benefits and 50 SADPs with either pediatric-only or family dental benefits. These plans were selected from the FFM and are meant to provide a general picture of the type of information available to consumers. While there could be significant differences within SBMs in terms of

information that is available to consumers, the analysis provides several important insights from the consumer perspective.

Overall, much more dental information is available for SADPs compared to medical plans with embedded pediatric dental benefits. This is primarily because the dental benefits information is limited within medical plan SBCs, which are a key resource for consumers as they navigate through the marketplace. In general, the majority of medical plans with embedded pediatric dental benefits do not clearly state whether they cover any services beyond preventive dental care. Information on coinsurance levels and copayment amounts is even more limited.

Additionally, it is often unclear from the consumer perspective how the deductible applies to pediatric dental benefits within medical plans. Only 20% of the medical plans we analyzed clearly stated that there was a separate dental deductible and even then, the amount of that deductible was not always made available. Consumers may assume that the medical deductible is applicable to pediatric dental benefits, but this is one area where transparency is a major issue.

Information on dental provider networks is also more limited within medical plans that offer embedded pediatric dental benefits. We found that all SADPs but only 56% of the medical plans provide a list of in-network dental providers that can be accessed directly through the SBC. In fact, 24% of the medical plans do not provide consumers with any information on in-network dental providers. We did not investigate dental provider network characteristics such as the number, geographic distribution, or quality of providers and this is an important area for future research.

Finally, we summarize information available on out-of-network coverage. Each medical plan and SADP we examined clearly states whether there is an additional cost for out-of-network services, or if out-of-network services are covered at all. We found that 48% of medical plans and 6% of SADPs do not cover dental services provided out-of-network.

Table 4 summarizes the actual plan characteristics for our random sample of plans. As outlined in the methods section, it is important to note that Table 4 is based on a much more thorough investigation of plans. We did supplemental web-based research and, if necessary, called the company offering the plan to collect information not available elsewhere. Even after these intensive data collection measures certain plan attributes remained unclear. Nevertheless, we feel Table 4 is best interpreted as information the consumer cannot necessarily access easily when shopping for plans, but will become aware of once they start using plan benefits.

In terms of which services are covered, all medical plans with embedded pediatric dental benefits and SADPs cover preventive services. SADPs are slightly more likely to cover restorative and orthodontia services. It is interesting to note that even after more extensive investigation, it is still unclear whether minor restorative services, major restorative services, and orthodontia services are covered within some medical plans.

There are important differences across plan types with respect to the dental deductible. When medical plans use a separate dental deductible, the average dental deductible is similar across these medical plans ($34) and the SADPs ($41). However, 34% of medical plans do not use a separate dental deductible. In these cases, the average combined medical plus dental deductible is $2,935.

Among medical plans that do not have a separate dental deductible, it is crucial to understand whether the deductible applies to all dental services or whether some are exempt. A high deductible with a long list of exempt services provides much higher financial

protection to consumers than a high deductible with few exempt services. We found that the vast majority of medical plans without a separate dental deductible do not apply the deductible to preventive services. Still, among the 12% that do there is an obvious concern that basic preventive dental care services are not first-dollar covered. Even among SADPs, 26% of plans apply the deductible to preventive services. While the average deductible amount for SADPs is much lower, this is still an important finding that some SADPs are not providing first-dollar coverage for basic preventive dental care services.

Figure 3 summarizes data on pediatric dental benefit premiums. We wanted to compare the average cost of obtaining pediatric dental benefits through three channels: a medical plan with embedded pediatric dental benefits; a high actuarial value SADP; and a low actuarial value SADP. As medical plans display only one premium, we developed a method to estimate the pediatric dental benefit premium within these plans. We took the difference between the average pediatric premium for silver medical plans that have an embedded pediatric dental benefit and the average for those that do not. This "shadow" premium is not observed anywhere but can be thought of as, on average, the incremental cost of obtaining pediatric dental benefits through a silver medical plan. In our calculation, we only include medical plans and SADPs from the 25 states on the FFM where SADPs and silver medical plans with and without embedded pediatric dental benefits are offered; in other words, the states where the consumer has all four choices available.

The average shadow premium across the 25 states is $5.11. This average represents the incremental cost of acquiring pediatric dental benefits through a silver medical plan. The shadow premium varies significantly across states, ranging from -$34.10 in South Dakota to $33.83 in Alaska. Many states actually have a negative shadow premium, meaning that silver medical plans without embedded pediatric dental benefits are, on average, more expensive than silver medical plans with embedded pediatric dental benefits.

The average high actuarial value SADP pediatric premium is $38.89, ranging from an average of $27.91 in Nebraska to $77.24 in Alaska. The average low actuarial value SADP pediatric premium is $30.98, ranging from an average of $23.32 in Nebraska to $52.93 in Alaska.

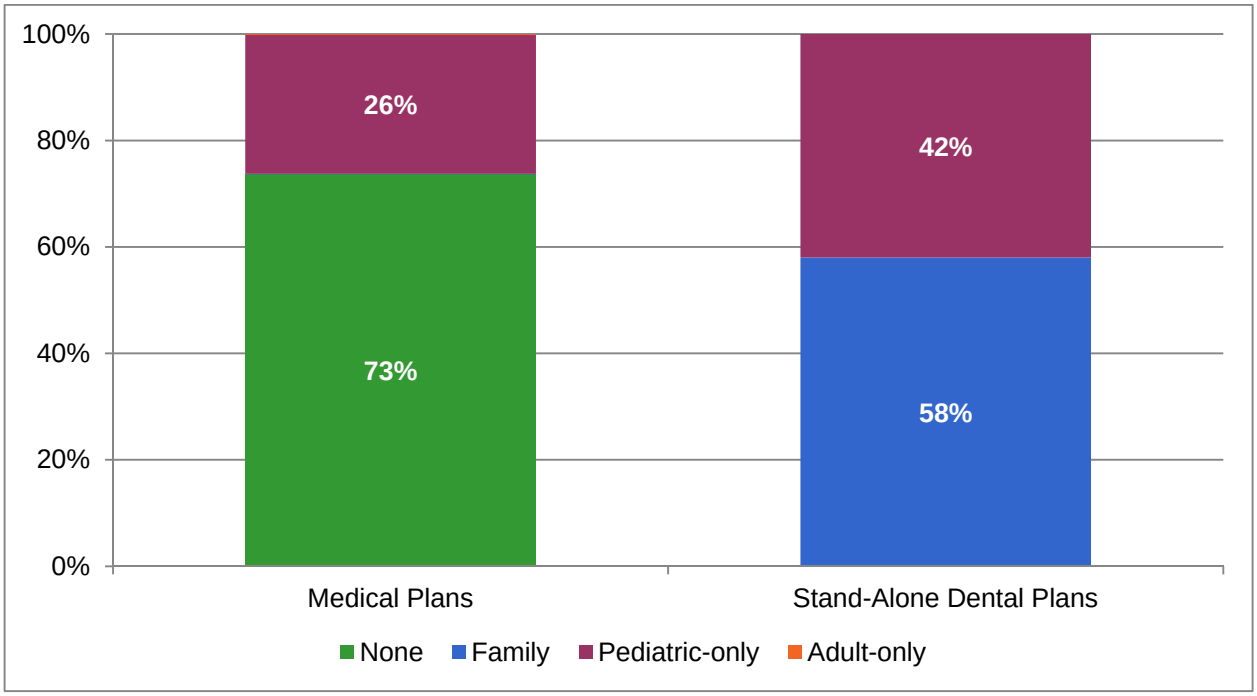
Finally, Figure 4 sheds light on the relationship between the number of plans offered and premiums. It examines whether increased competition among SADPs and increased choice for consumers leads to lower premiums. We found no relationship between the number of SADPs being offered within a state and the average pediatric premium. We also examined whether the presence of medical plans with embedded pediatric dental benefits impacts premium levels for SADPs. We did not find any impact (results not shown). These initial findings suggest that increased competition in terms of the number of plans offered may not lead to lower premiums. However, a more robust analysis is needed to verify this result. Interestingly, Figure 4 also demonstrates that the difference in the average premium for high and low actuarial value dental plans varies across states and is actually negative in one state.

Table 1: States Included in our Analysis

	Federally-Facilitated Marketplace	State-Based Marketplace
Included in our Analysis	AK, AL, AR, AZ, DE, FL, GA, IA, ID, IL, IN, KS, LA, ME, MI, MS, MO, MT, NE, NH, NJ, NM, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WV, WY	CA, MN, NV, VT, WA
Not included in our Analysis	-	CO, CT, DC, HI, KY, MD, MA, NY, OR, RI

Source: CMS. **Note:** Idaho and New Mexico are temporarily running through the FFM but plan to establish their own SBM in the near future.

Figure 1: Dental Benefits Available within Medical and Stand-Alone Dental Plans



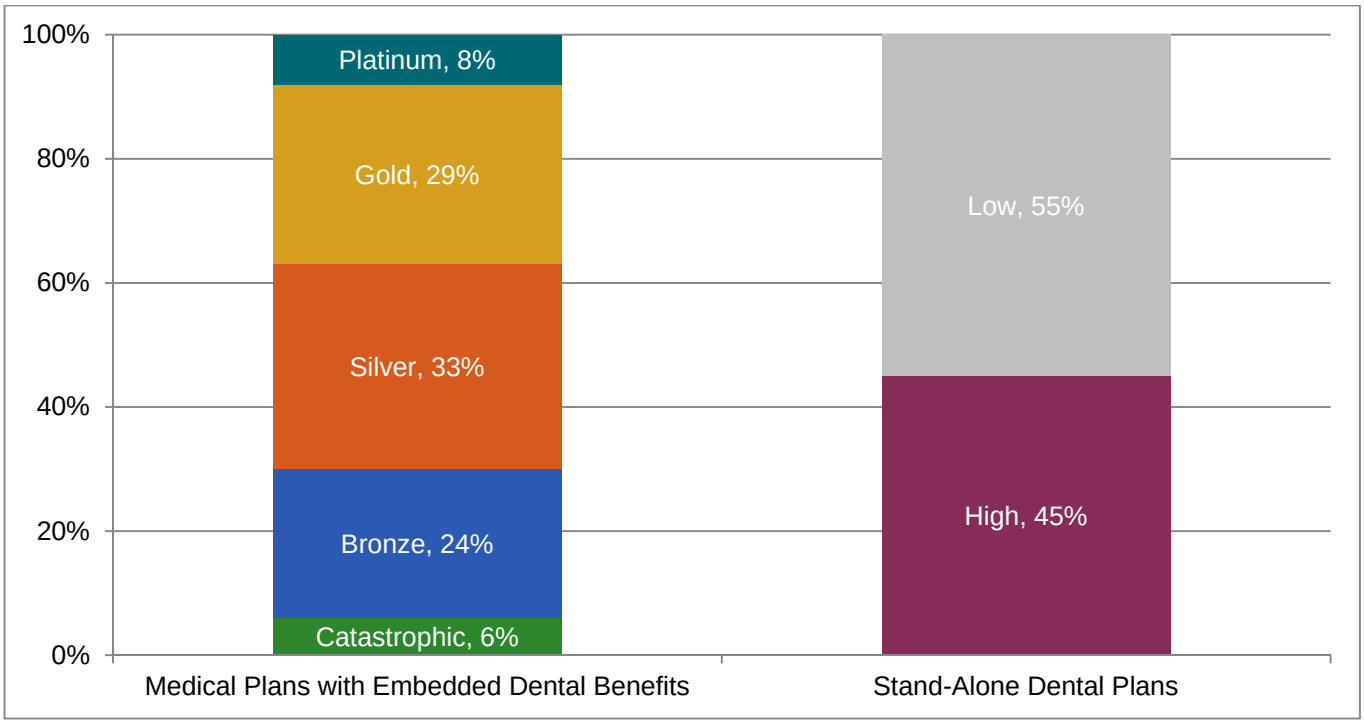
Source: ADA Health Policy Institute analysis of data from the FFM and select SBMs. **Notes**: We analyzed all medical plans and SADPs offered for 36 states operating through the FFM and 5 states operating SBMs. For FFM states, we analyzed unique plans identified by a unique Plan ID. For SBMs, we visited each state's marketplace website and analyzed documents (CA, VT, and WA) or browsed plans (MN and NV). We then analyzed each unique medical plan and SADP for the type of dental benefits offered. Analysis is based on 3,180 medical plans and 697 SADPs.

Table 2: Percentage of Medical Plans with Embedded Pediatric Dental Benefits

	State
0%	AR, CA, MS, MT, NJ, NM, UT
<50%	AL, AZ, FL, GA, IA, ID, IL, IN, KS, ME, MI, MN, MO, NV, NH, OH, OK, SC, SD, TX, VA, WI
50-99%	AK, DE, LA, NC, ND, NE, PA, TN, WA, WY
100%	VT, WV

Source: ADA Health Policy Institute analysis of data from the FFM and select SBMs. **Notes**: We analyzed all medical plans offered for 36 states operating through the FFM and 5 states operating SBMs. For FFM states, we analyzed unique plans identified by unique Plan ID. For SBMs, we visited each state's marketplace website and analyzed documents (CA, VT, and WA) or browsed plans (MN and NV). We then analyzed each unique medical plan for the type of dental benefits offered. Analysis is based on 3,180 medical plans.

Figure 2: Actuarial Value of Medical and Stand-Alone Dental Plans



Source: ADA Health Policy Institute analysis of data from the FFM and select SBMs. **Notes**: We analyzed all medical plans offered for 36 states operating through the FFM and 5 states operating SBMs. For FFM states, we analyzed unique plans identified by unique Plan ID. For SBMs, we visited each state's marketplace website and analyzed documents (CA, VT, and WA) or browsed plans (MN and NV). We categorized plans by actuarial values assigned by CMS. Analysis is based on 866 medical plans with embedded adult, family, or pediatric dental benefits and 697 SADPs.

Table 3: Information Available to Consumers on Plan Characteristics

	Medical Plans with Embedded Pediatric Dental Benefits	Stand-Alone Dental Plans
Does the dental plan indicate coverage of preventive services?		
Yes	100%	100%
No	0%	0%
Unclear	0%	0%
If yes, consumers can determine:		
Whether the deductible applies	14%	18%
If there is a copay	14%	14%
Coinsurance level	100%	100%
Does the plan indicate coverage of restorative services?		
Yes	8%	98%
No	0%	0%
Unclear	92%	2%
If yes, consumers can determine:		
Whether the deductible applies	100%	71%
If there is a copay	0%	12%
Coinsurance level	100%	100%
Does the plan indicate coverage of orthodontia services?		
Yes	8%	96%
No	0%	2%
Unclear	92%	2%
If yes, consumers can determine:		
Whether the deductible applies	100%	44%
If there is a copay	0%	8%
Coinsurance level	100%	100%
Does the plan indicate that there is a separate dental deductible?		
Yes, and the amount is shown	14%	100%
Yes, but the amount is not shown	6%	0%
No	0%	0%
Unclear	80%	0%
Does the plan provide a list of in-network dental providers?		
Yes, list is accessed from SBC	56%	100%
Yes, but list is not accessed from SBC	20%	0%
No	24%	0%
Does the plan indicate coverage of dental services out-of-network?		
Yes	52%	94%
No	48%	6%
Unclear	0%	0%

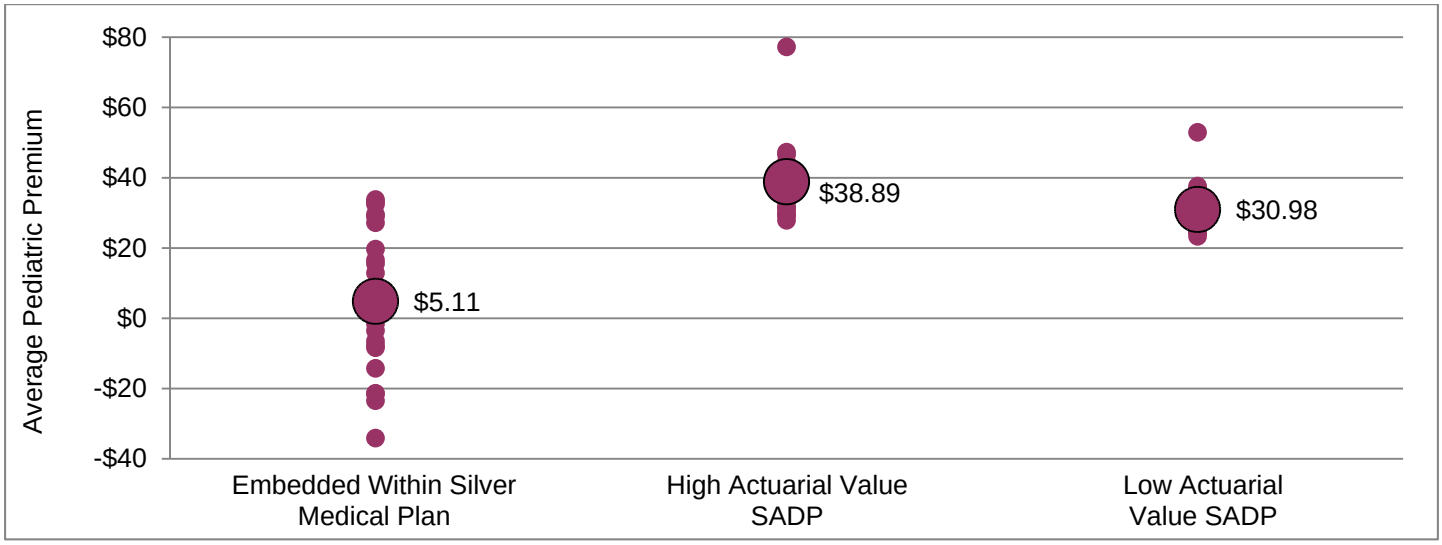
Source: ADA Health Policy Institute analysis of a random sample of 50 medical plans with embedded pediatric dental benefits and 50 SADPs from the FFM. **Notes:** We randomly selected 50 medical plans with embedded pediatric or family dental benefits and 50 SADPs with either pediatric or family dental benefits. We reviewed the SBC for each plan, considering information made available through the SBC as information available to the consumer. We treated the SBC as information available to the consumer because the hyperlink to the SBC is made available on the FFM; thus it is easily accessible to a consumer shopping the FFM. We did not include SBM plans in our random sample because we could not simulate shopping as a consumer on the SBMs for CA, VT, and WA without creating a user account.

Table 4: Summary of Plan Characteristics

	Medical Plans with Embedded Pediatric Dental Benefits	Stand-Alone Dental Plans
Is there a separate dental deductible?		
Yes	42%	100%
Average amount	$34.21	$41.10
No	34%	0%
Average amount	$2,935.29	N/A
Unclear	24%	0%
Are preventive services covered?		
Yes	100%	100%
No	0%	0%
Unclear	0%	0%
If yes, average that plan pays	98%	97%
If preventive services are covered, does the deductible apply?		
Yes, medical deductible is used	12%	0%
Yes, dental deductible is used	2%	26%
No	86%	74%
Unclear	0%	0%
Are restorative services covered?		
Yes	84%	100%
No	0%	0%
Unclear	16%	0%
If yes, average that plan pays	Minor: 71% Major: 60%	Minor: 65% Major: 49%
If restorative services are covered, does the deductible apply?		
Yes	73%	70%
No	27%	30%
Unclear	0%	0%
Are orthodontia services covered?		
Yes	64%	96%
No	4%	4%
Unclear	32%	0%
If yes, average that plan pays	55%	50%
If orthodontia services are covered, does the deductible apply?		
Yes	78%	44%
No	22%	56%
Unclear	0%	0%
Is there a copayment for any services?		
Yes	16%	16%
No	52%	84%
Unclear	32%	0%

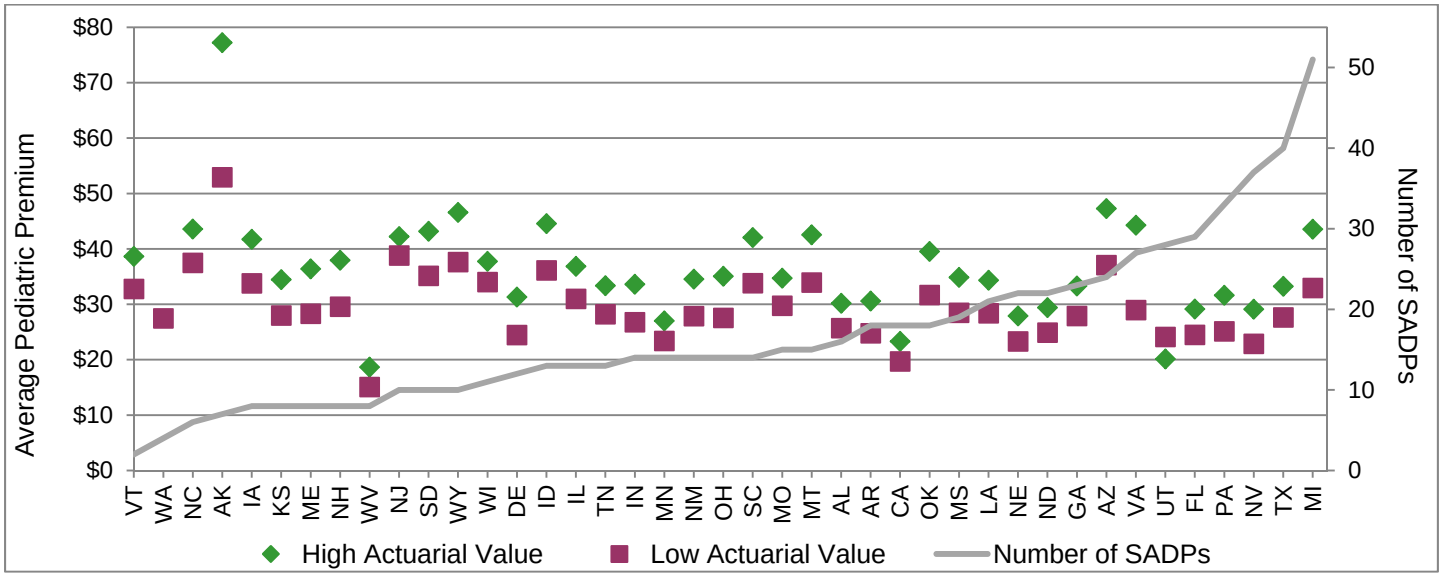
Source: ADA Health Policy Institute analysis of a random sample of 50 medical plans with embedded pediatric dental benefits and 50 SADPs from the FFM. Supplemental web searches and phone calls for medical plans. **Notes:** We randomly selected 50 medical plans with embedded pediatric or family dental benefits and 50 SADPs with either pediatric or family dental benefits. We reviewed the SBC for each plan. We did not include SBM plans in our random sample because we could not simulate shopping as a consumer on the SBMs for CA, VT, and WA without creating a user account. We collected information on deductibles, out-of-pocket maximums, dental service coinsurance levels, and dental services covered. If SBCs did not have all of the information, we searched for information through internet searches. If information was still not available, we telephoned the insurance company offering the plan.

Figure 3: Average Monthly Pediatric Premium for Dental Benefits by Plan Type



Source: ADA Health Policy Institute analysis of data from the FFM. **Notes**: Each small data point represents the average premium in a state and each large data point represents the average across all states (unweighted). Premiums were analyzed separately for silver medical plans with and without embedded pediatric dental benefits, high actuarial value SADPs, and low actuarial value SADPs. States were included in the analysis only if there were silver medical plans with and without embedded pediatric dental benefits, high actuarial value SADPs, and low actuarial value SADPs available for purchase. This resulted in 25 states being included. States were excluded if all four types of plans were not available for purchase. This resulted in 11 states being excluded. To calculate the premium for pediatric dental benefits when they are embedded within a silver medical plan in a state, we first calculated the average premium for silver medical plans that have embedded pediatric dental benefits in a state. We then subtracted the average premium for silver medical plans that do not have embedded pediatric dental benefits in that state. This is a 'shadow' premium in the sense that it is not observed.

Figure 4: Average Monthly Pediatric Premium for Stand-Alone Dental Plans by State



Source: ADA Health Policy Institute analysis of data from FFM and select SBMs. **Notes:** We summarized the average pediatric premium for high actuarial value SADPs and low actuarial value SADPs by state. We first calculated the average pediatric premium for each unique SADP offered in a state. We then average the pediatric premium for all high actuarial value SADPs in a state, and all low actuarial value SADPs in a state. We also calculated the number of unique SADPs offered in each state. The states are ordered from left to right along the x-axis from the state with the fewest number of SADPs offered (VT) to the state with the highest number of SADPs offered (MI). 41 states are included in this analysis.

Discussion

Our analysis has uncovered several important findings related to dental benefit offerings within the health insurance marketplaces. First, there is much more information related to dental benefits available to consumers for SADPs compared to medical plans with embedded dental benefits. Second, after considerable effort to fill many information gaps we found that covered services and coinsurance levels are very similar for both types of plans. Third, deductibles are significantly lower within SADPs, due to the fact that many medical plans with embedded dental benefits use a single deductible for medical and dental services combined. However, it is important to note that most of these medical plans do not apply the deductible to preventive dental services. Fourth, out-of-network coverage is much more limited for medical plans with embedded dental benefits compared to SADPs. This is especially important because information on dental provider networks is more limited within these medical plans. Fifth, the cost of purchasing pediatric dental benefits through medical plans appears to be significantly lower than through SADPs.

Our findings provide early insights into how the establishment of health insurance marketplaces under the ACA could affect dental benefits coverage for children and, ultimately, access to dental care. The fact that there is often limited information available for consumers to make meaningful comparisons across plans has important implications. With less-than-full information it is challenging for consumers to make optimal choices. The dental benefit transparency issues we identified are understandable given the challenges surrounding the launch of the FFM and many state marketplaces. As these marketplaces continue to evolve, however, effort should be given to improving the information base and presenting dental benefit plan comparisons in a user friendly, easy to understand way.

The ACA gives states the authority to customize many key aspects of their health insurance marketplaces, including how pediatric dental benefits are offered,[55] and indeed we found significant variation. In some states, none of the medical plans have an embedded dental benefit. In other states, all of them do. SADPs are offered in all states. It is unclear whether these differences in how dental benefits are offered are a result of policy decisions by health insurance marketplace regulatory agencies or a result of other factors. Either way, understanding the implications of these alternative marketplace arrangements on purchasing decisions and, ultimately, access to dental care is extremely important. For example, if all medical plans were required to have an embedded dental benefit, then expanding coverage becomes very easy. If states require that pediatric dental benefits be purchased this also ensures full coverage. Understanding the implications of the alternative marketplace set ups is especially important given the lack of a true mandate. Early enrollment results from California, where pediatric dental benefits can only be purchased as a SADP, confirm the importance of this issue. Through January 2014, only 27% of children enrolling in medical plans also enrolled in a SADP.[56]

Beyond coverage expansion, if the nature of dental benefits differs by whether or not they are embedded in a medical plan – and we found this to be the case – there are further implications of alternative paths to dental coverage that warrant investigation.

Another potential concern is the fact that both medical plans and SADPs apply deductibles to preventive pediatric dental services in some cases. This practice is permitted, as these services are not guaranteed to

be cost free like preventive medical services.[57,58] We feel that this issue needs to be revisited in the next round of health insurance marketplace regulation changes. Pediatric dental care is an important component of primary care. But the lack of first-dollar coverage for basic preventive dental services for children in some plans could impose financial barriers to care, counteracting the purpose of making pediatric dental benefits an essential health benefit.

Our analysis shows that, on average, the cost of obtaining pediatric dental benefits through medical plans is significantly lower than through SADPs. There are a variety of factors that could explain this including benefit differences, out-of-network coverage limitations, and higher deductibles. We did not analyze differences in the size, location, and quality of dental provider networks and this may also be an important factor. The fact that in many states medical plans that include embedded pediatric dental benefits cost, on average, less than those that do not suggests that attributes we did not capture may indeed be important to consumer choices. While further analysis is needed, we nevertheless feel that our finding related to premiums is extremely important. If consumers shop primarily on price, either because price is the most important attribute or because information on other attributes is less readily available, then one would expect a significant uptake of the embedded option. If, however, lower deductibles and more extensive out-of-network coverage are highly valued by consumers, then SADPs could continue to be the primary path to obtaining pediatric dental benefits. The use of narrow networks and limiting coverage for out-of-network services is an increasingly important cost-containment strategy among insurers.[59] The evidence is mixed regarding how consumers value enhanced provider choice compared to lower costs.[60]

This initial research on dental benefit offerings helps shed light on the evolving dental benefits landscape. It also raises several questions that require further analysis. In our next phase of research, we plan to investigate dental provider networks in greater detail and research how different marketplace set ups actually impact consumer purchase decisions. As the ACA continues to reshape the U.S. health care system, it is important to generate evidence on these and other issues in the dental care sector to help guide policy.

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