

Research Brief

Including Child Dental Benefits in Medical Plans in California Had Limited Impact on Premiums

Authors: Kamyar Nasseh, Ph.D.; Cassandra Yarbrough, M.P.P.; Marko Vujcic, Ph.D.

The Health Policy Institute (HPI) is a thought leader and trusted source for policy knowledge on critical issues affecting the U.S. dental care system. HPI strives to generate, synthesize, and disseminate innovative research for policy makers, oral health advocates, and dental care providers.

Who We Are

HPI's interdisciplinary team of health economists, statisticians, and analysts has extensive expertise in health systems policy research. HPI staff routinely collaborates with researchers in academia and policy think tanks.

Contact Us

Contact the Health Policy Institute for more information on products and services at hpi@ada.org or call 312.440.2928.

Key Messages

- *In 2015, all medical plans offered through Covered California include embedded pediatric dental benefits. This represents a significant change from 2014, when no medical plans were embedded.*
- *We estimate that this policy change led to about a \$7 increase in child medical plan monthly premiums. It also resulted in a slight and statistically insignificant decline in child stand-alone dental plan (SADP) premiums. Potential declines in SADP premiums will have to be monitored in the coming years.*
- *While the California experience suggests that child dental benefits obtained via embedded medical plans are less costly than SADPs with respect to monthly premiums, further research is needed to examine differences in deductible arrangements, total out-of-pocket costs, and provider networks.*

Introduction

Pediatric dental benefits are one of the ten essential health benefits that all small group and individual market health plans are required to cover.¹ However, health plans sold through the health insurance marketplaces are not required to include pediatric dental benefits as long as there are stand-alone dental plans (SADPs) available for purchase.² In most states, consumers can purchase pediatric dental benefits through the marketplaces in one of two ways in 2015: through an SADP or through a medical plan that has embedded or bundled pediatric dental benefits.³

In 2015, more medical plans sold through the health insurance marketplaces include embedded pediatric dental benefits compared to 2014.⁴ However, in most states, consumers are not required to purchase dental benefits for their child, nor are they penalized for failing

to do so.⁵ In other words, the pediatric dental benefits requirement is not a true mandate

Nevertheless, some states have elected to enforce the pediatric dental benefits requirement in their marketplace either by requiring SADP purchases or requiring all medical plans sold through the marketplace to include embedded pediatric dental benefits.⁴

All of the medical plans offered in California's 2015 health insurance marketplace, Covered California, include embedded pediatric dental benefits. Each embedded medical plan is required to cover a minimum set of pediatric dental services at certain levels of cost-sharing, ensuring that all children gaining health insurance through California's marketplace also gain dental benefits. This is a significant change from 2014 when medical plans did not offer embedded pediatric dental benefits.

In Washington, none of the medical plans offered through the health insurance marketplace in 2014 or 2015 include embedded pediatric dental benefits. Arkansas and New Mexico are other states where no medical plans have embedded pediatric dental benefits. Consumers must purchase both a medical plan and an SADP for their child prior to exiting the marketplace if they wish to obtain child dental benefits in these states. In both 2014 and 2015, the Washington marketplace requires that consumers purchase a dental plan for their child prior to checking out of the marketplace. Colorado, Kentucky and Nevada also enforce SADP purchases.⁶

This policy change in California will impact the uptake of pediatric dental benefits significantly. In 2014, only 36 percent of children obtaining health insurance through Covered California obtained a dental plan. In 2015, this should increase to 100 percent due to the policy change. But the policy change could have other

important effects. It could significantly change the marginal cost of obtaining pediatric dental benefits. If the average increase in health insurance premiums resulting from the mandate to embed dental benefits is significantly lower than the average SADP premium, then average "affordability" will improve. Furthermore, the introduction of embedded dental benefits in California could impact SADP premiums. Greater competition from embedded plans may lead insurers that offer SADPs to lower their premiums.

In this research brief, we take advantage of the 2015 policy change in California to examine the impact of embedding pediatric dental benefits within medical plans on medical plan and SADP premiums.

Data & Methods

Our approach in this analysis is to compare the experience in California to Washington. In 2014, both California and Washington offered medical plans without embedded pediatric dental benefits. However, in 2015, California embedded all its pediatric medical plans with dental benefits while Washington continued to prohibit embedding. Because no policy change occurred in Washington, we selected it as a control state.

We collected 2014 and 2015 embedded medical plan and SADP data from various sources. For California, we collected premium and plan information from the California Department of Insurance,⁷ the California Department of Managed Health Care,⁸ the California Health Benefit Exchange Data & Research website⁹ and Covered California.^{10,11,12,13} For Washington, we collected premium and plan information from the Washington State Office of the Insurance Commissioner¹⁴ and Washington Healthplanfinder.^{15,16} These data include information on child dental premiums, plan actuarial values (Catastrophic, Bronze,

Silver, Gold and Platinum for embedded medical plans and High and Low for SADPs), plan type (Exclusive Provider Organization (EPO), Preferred Provider Organization (PPO), Health Savings Account (HSA), Health Maintenance Organization (HMO), a combination of these or “other”), insurer name and rating area. Insurers can offer the same plan across different rating areas, although the premiums associated with these plans often differ. In California and Washington, rating area boundaries are determined by demographics at the county level. In these two states, rating areas contain single or multiple geographic counties. In 2015, California had 19 and Washington had 5 rating areas. Identical plans offered in multiple rating areas in a state were given the same unique plan ID.

In 2014, 81 medical plans (without embedded dental benefits) and 18 SADPs were offered through the California marketplace, while in 2015, 76 embedded medical plans and 8 SADPs were offered.¹⁷ In Washington, 38 medical plans (without embedded dental benefits) and 4 SADPs were offered through the 2014 marketplace. In 2015, 82 medical plans (without embedded dental benefits) and 6 SADPs were offered in Washington.

In order to assess the impact of introducing embedded medical plans to the California marketplace in 2015, we conducted a difference-in-differences analysis. In our setup, California is the “treatment” state and Washington is the “control” state. We estimated the following model to measure the impact of the California reform on child premiums for embedded medical plans and SADPs:

$$Child_{premium} = \beta_0 + \beta_1 CA + \beta_2 Year_{2015} + \beta_3 CA * Year_{2015} + \beta_4 X + u$$

The dependent variable is the child premium for a pediatric medical plan or an SADP. On the right hand

side, X is a vector of control covariates that include rating area fixed effects and categorical variables for metal level, insurer and plan type (EPO, PPO, HMO, etc.). $Year_{2015}$ is a binary indicator variable identifying a medical plan or SADP that is offered in 2015 and CA is a binary indicator variable identifying a plan offered in California. The coefficient β_3 measures the policy impact from the introduction of embedded dental benefits on child premiums in California. Estimated standard errors are clustered by Plan ID because unique plans are offered across different rating areas in California and Washington. We used linear regression to estimate this policy model.

Results

Tables 1a and 1b show the actual average monthly child premiums in 2014 and 2015 for medical plans and SADPs in California and Washington. The average monthly child premium for a medical plan increased by \$6.81 in California and decreased by \$2.17 in Washington between 2014 and 2015. For SADPs, the average monthly child premium decreased by \$0.79 in California and increased by \$1.31 in Washington. The unadjusted difference-in-difference estimates are not statistically significant.

However, after including rating area fixed effects and categorical variables for actuarial level, insurer and plan type, changes in monthly child premiums for medical plans become statistically significant. Specifically, there is a statistically significant increase in monthly child premiums for medical plans in California over and above any change in monthly child premiums for medical plans in Washington. This means that the introduction of embedded pediatric dental benefits in medical plans in the California marketplace increased medical plan child premiums by about \$6.69 on average (Table 2). We call this the “shadow” premium of an embedded dental benefit

within a medical plan because it is never actually observed by the consumer and is “rolled in” to the overall premium. As for SADPs, the policy change in California led to a reduction in

average monthly child premiums by about \$3.88 in California relative to any change in Washington, although this change was not statistically significant.

Table 1a: Average Monthly Child Premium for Medical Plans in California and Washington (2014 and 2015)

State	Year		Difference
	2014	2015	
California	\$161.64	\$168.45	\$6.81
Washington	\$146.69	\$144.52	-\$2.17
<i>Difference</i>	\$14.95	\$23.94	
<i>Difference-in-Difference:</i>			\$8.98

Notes: Difference-in-differences are not statistically significant. This estimate does not control for rating area, plan type, insurer or metal level.

Table 1b: Average Monthly Child Premium for SADPs in California and Washington (2014 and 2015)

State	Year		Difference
	2014	2015	
California	\$21.51	\$20.71	-\$0.79
Washington	\$28.13	\$29.44	\$1.31
<i>Difference</i>	-\$6.63	-\$8.73	
<i>Difference-in-Difference:</i>			-\$2.10

Notes: Difference-in-differences are not statistically significant. This estimate does not control for rating area, plan type, insurer or metal level.

Table 2: Impact of California Embedding Dental Benefits on Monthly Child Premiums for Medical Plans and SADPs - Adjusted Difference-In-Difference Estimates

Variable	Dependent Variable: Child Premium for Medical Plan	Dependent Variable: Child Premium for SADP
Adjusted Difference-in-Difference	\$6.69*	-\$3.88

Notes: Models include rating area fixed effects and categorical variables for metal level, insurer and plan type. Robust standard errors are clustered at the plan level. *-Significant at 5% level.

Discussion

Based on the experience in California, we estimated that embedding child dental benefits within medical plans led to, on average, a \$6.69 increase in monthly premiums. This \$6.69 monthly “shadow” premium is much less than the average monthly child premium for a SADP (around \$20 in California and \$29 in Washington). At the same time, child premiums for SADPs declined slightly in California, although this change was not statistically significant. It remains to be seen if this slight drop in child premiums for SADPs in the California marketplace continues in 2016.

Economic theory would predict that premiums for SADPs would fall in response to medical insurers offering more plans with embedded dental benefits if such plans provide comparable coverage at lower prices.

Our findings from the policy reform in California are consistent with national evidence. Between 2014 and 2015, nationally, more medical plans offered embedded child dental benefits. When we look at the monthly “shadow” premium for embedded dental benefits nationally, we see the same market changes that we see in California. The national average monthly “shadow” premium for pediatric dental benefits embedded in a silver medical plan was \$5.11 in 2014 and \$16.21 in 2015, far below the average child monthly premium for SADPs.⁴ At the same time that more embedding of dental benefits is occurring, average monthly premiums for SADPs are declining as well.⁴

Recent research has shown that medical plans with embedded child dental benefits cover many of the same services as SADPs, often at lower levels of co-insurance or lower co-pays for preventive services.⁴ Further research is needed to understand the mechanism through which medical plans appear to

offer dental benefits at lower monthly premiums. It could be, for example, that medical plans with embedded dental benefits are able to spread risk over a larger pool of beneficiaries. Because SADPs are generally a voluntary purchase, we speculate that individuals with the greatest need for dental care are more likely to purchase them. This could lead to adverse selection and, all else equal, higher monthly premiums. Even in states that require the purchase of SADPs, the requirement applies only to children⁶ whereas some childless adults are included in the risk pool among embedded plans.

There may be other important differences between embedded dental benefits and SADPs that could account for the monthly premium difference, including differences in provider networks or cost-sharing. For example, deductible, co-insurance and co-pay arrangements may differ between embedded medical plans and SADPs. However, in California, the embedded medical plans offered through the 2015 marketplace are held to standard pediatric dental benefit design regulations that specify covered services, co-insure and co-pay amounts, and a \$0 deductible for dental care.¹⁸ Out-of-pocket costs will differ if embedded medical plans use a single out-of-pocket maximum for all covered services, including dental care, but it is not clear in which direction. Typical out-of-pocket costs for dental care under embedded medical plans will depend on the combination of both medical and dental care utilization. We plan further research to investigate this in more detail.

Interestingly, the dental benefits within embedded medical plans in the California marketplace are actually provided by traditional SADP insurers.¹⁹

Overall, in our view, there is now compelling evidence to suggest that obtaining child dental benefits via

medical plans is far less costly to child consumers in terms of monthly premiums than obtaining dental benefits via SADPs. Additionally, the available evidence outside of California suggests that the dental benefits offered through embedded medical plans are very similar to those offered through traditional SADPs, with respect to services covered and cost-sharing arrangements for preventive services. Other aspects, such as total out-of-pocket costs and provider networks could differ between embedded medical plans and SADPs.

The Health Policy Institute plans future research related to dental benefit offerings and purchases in health insurance marketplaces.

This Research Brief was published by the American Dental Association's Health Policy Institute.

211 E. Chicago Avenue
Chicago, Illinois 60611
312.440.2928
hpi@ada.org

For more information on products and services, please visit our website, www.ada.org/hpi.

References

- ¹ H.R. 3590. The Patient Protection and Affordable Care Act, 42 United States Code Sec. 1302(b)(1)(J) [United States Government Printing Office web site]. 2010. Available at: <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>. Accessed April 6, 2015.
- ² H.R. 3590. The Patient Protection and Affordable Care Act, 42 United States Code Sec. 1302(b)(4)(F) [United States Government Printing Office web site]. 2010. Available at: <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>. Accessed April 6, 2015.
- ³ Yarbrough C, Vujicic M, Nasseh K. Health Insurance Marketplaces Offer a Variety of Dental Benefit Options, but Information Availability is an Issue. Health Policy Institute Research Brief. American Dental Association. March 2014. Available from: http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0314_1.pdf. Accessed April 6, 2015.
- ⁴ Yarbrough C, Vujicic M, Nasseh K. More dental benefits options in 2015 Health Insurance Marketplaces. Health Policy Institute Research Brief. American Dental Association. February 2015. Available from: http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0215_1.ashx. Accessed April 6, 2014.
- ⁵ The Henry J. Kaiser Family Foundation. Marketplace Eligibility, Enrollment Periods, Plans and Premiums. Available from: <http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/>. Accessed April 6, 2015.
- ⁶ Insure.com. How to find a health plan with good dental coverage for your child. January 12, 2015. Available from: <http://www.thestreet.com/story/13007923/1/how-to-find-a-health-plan-with-good-dental-coverage-for-your-children.html>. Accessed April 6, 2015.
- ⁷ California Department of Insurance. Rate Filing. Available from: <https://interactive.web.insurance.ca.gov/apex/f?p=102:2:0::NO>. Accessed January 14, 2015.
- ⁸ California Department of Managed Health Care. Data & Research. Available from: http://www.dmhc.ca.gov/DataResearch.aspx#.VR2fD_nF_14. Accessed January 14, 2015.
- ⁹ California Health Benefit Exchange. 2015 Product Prices for all Health Insurance Companies (xlsx). Available from: <http://hbex.coveredca.com/data-research/>. Accessed November 20, 2014.
- ¹⁰ Covered California. Health Insurance Companies and Plan Rates for 2014. July 2014. Available from: <https://www.coveredca.com/PDFs/CC-health-plans-booklet-rev4.pdf>. Accessed February 26, 2015.
- ¹¹ Covered California. Children's Dental Insurance Plan Rates 2014. September 2013. Available from: https://www.coveredca.com/PDFs/CC_Childrens_dental_plan_rates.pdf. Accessed February 26, 2015.
- ¹² Covered California. Health Insurance Companies and Plan Rates for 2015. October 2014. Available from: <https://www.coveredca.com/PDFs/CC-health-plans-booklet-2015.pdf>. Accessed February 26, 2015.
- ¹³ Covered California. Family Dental Plans and Rates for 2015. August 2014. Available from: www.coveredca.com. Accessed September 18, 2014.
- ¹⁴ Washington State Office of the Insurance Commissioner. Health Insurance Rate Filings. Available from: <http://www.insurance.wa.gov/>. Accessed November 20, 2014.
- ¹⁵ Washington Health Plan Finder. 2015 Qualified Health Plan and Qualified Dental Plan Certification Requests. Available from: http://wahbexchange.org/files/6814/0925/1849/WAHBE_Certification_Request_2015_Final.pdf. Accessed February 26, 2015.
- ¹⁶ Washington Health Plan Finder. Health Insurance Companies and Plan Rates for 2014. Available from: http://wahbexchange.org/files/3313/7877/6716/Health_Insurance_Companies_and_Plan_Rates_2014_9.9.13.pdf. Accessed February 26, 2015.
- ¹⁷ Covered California intended to offer family SADPs in the 2015 marketplace. However, due to technical issues with California's health insurance marketplace website, there were no SADPs offered through the 2015 individual health insurance marketplace. We downloaded 2015 individual market family plan child premium information in September 2014, prior to this change. For more information, please see: Covered California News. Covered California plans to

offer expanded dental services for children and new coverage for adults. August 20, 2014. Available from: <http://news.coveredca.com/2014/08/covered-california-plans-to-offer.html>. Accessed May 5, 2015. See also: Hellesen S. Covered California delays adult dental options. California Healthcare Foundation Center for Health Reporting. February 13, 2015. Available from: <http://centerforhealthreporting.org/article/covered-california-delays-adult-dental-options>. Accessed May 5, 2015.

¹⁸ State of California Office of Administrative Law. Notice of Approval of Emergency Regulatory Action re: California Health Benefit Exchange. Title 10, California Code of Regulations. Government Code Sections 11346.1 and 11349.6. OAL File No. 2014-0512-01 E.

¹⁹ Covered California. Covered California plans to offer expanded dental services for children and new coverage for adults. August 20, 2014. Available from: <http://news.coveredca.com/2014/08/covered-california-plans-to-offer.html>. Accessed April 15, 2015.

Suggested Citation

Nasseh K, Yarbrough C, Vujicic M. Including child dental benefits in medical plans in California had limited impact on premiums. Health Policy Institute Research Brief. American Dental Association. May 2015. Available from: http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0515_1.ashx