Estimating Premium and Out-of-Pocket Outlays Under All Child Dental Coverage Options in the Federally Facilitated Marketplace

Marko Vujicic, PhD, and Cassandra Yarbrough, MPP

Objective To estimate premium and out-of-pocket costs for child dental care services under various dental coverage options offered within the federally facilitated marketplace.

Study design We estimated premium and out-of-pocket costs for child dental care services for 12 patient profiles, which vary by dental care use and spending. We did this for 1039 medical plans that include child dental coverage, 2703 medical plans that do not include child dental coverage, and 583 stand-alone dental plans for the 2015 plan year. Our analysis is based on plan data from the Center for Consumer Information and Insurance Oversight and Data.HealthCare.Gov.

Results On average, expected total financial outlays for child dental care services were lower when dental coverage was embedded within a medical plan compared with the alternative of a stand-alone dental plan. The difference, however, in average expected out-of-pocket spending varied significantly for our 12 patient profiles. Older children who are very high users of dental care, for example, have lower expected out-of-pocket costs under a stand-alone dental plan. For the vast majority of other age groups and dental care use profiles, the reverse holds.

Conclusions Our results show that embedding dental coverage within medical plans, on average, results in lower total financial outlays for child beneficiaries. Although our results are specific to the federally facilitated marketplace, they hold lessons for both state-based marketplaces and the general private health insurance and dental benefits market, as well. *(J Pediatr 2017;182:349-55).*

Dental caries is the most common chronic disease among children in the US.[1] Routine dental care is important in promoting children's oral health. Child dental care coverage is mandatory in Medicaid and the Children's Health Insurance Program and is one of 10 essential health benefits under the Affordable Care Act (ACA). Still, disparities in dental care use between children insured publically and privately remain.[2]

The implementation of the child dental coverage mandate has been a challenge. Private dental coverage traditionally has been provided separately from medical coverage through stand-alone dental plans (SADPs). The ACA maintained this separation. Medical plans are not required to cover dental care for children if SADPs are available for purchase in the health insurance marketplaces. Only 35.7% of medical plans offered in the 2015 marketplace included dental coverage for children.[3]

Because dental coverage has been separated from medical coverage and the purchase of an SADP typically is not required in the marketplace, dental coverage expansion under the ACA has been limited. According to the most recent analysis, only 13.2% of children who obtained a medical plan in the federally facilitated marketplace (FFM) also obtained an SADP.[4] Although some states, such as California, only offer medical plans that include dental coverage for children,[5] this is not the norm.[6] Thus, the number of children obtaining dental coverage is expected to be much lower than those with medical coverage, although no data are available yet.

Providing dental coverage through a separate plan also has implications for consumer financial protection. Several provisions of the ACA limit consumer out-of-pocket spending, including premium subsidies, annual out-of-pocket maximums, and medical loss ratio restrictions on plans. Many of these provisions do not apply to SADPs. For example, when dental coverage is obtained through a medical plan, premium subsidies partly offset the cost of dental coverage. When dental coverage is obtained through an SADP, however, often it is not eligible for premium subsidies.[7] In contrast, SADPs might be more effective at limiting consumer out-of-pocket spending on dental care because they have dental-only provisions. For example, medical plans with embedded dental coverage might use a single medical/dental deductible whereas SADPs, by definition, have a dental-only deductible. Depending on what dental care services are exempt from the common medical/dental deductible, this could have a significant impact on out-of-pocket dental care spending.[8] Analysis from 2015 found that 95% of medical plans with embedded dental coverage offered in the state and

ACA	Affordable Care Act
CCIIO	Center for Consumer Information and Insurance Oversight
FFM	Federally facilitated marketplace
SADP	Stand-alone dental plan

From the Health Policy Institute, American Dental Association, Chicago, IL

Research for this report is based partly on claims data compiled and maintained by Truven Health Analytics, MarketScan Research Databases. The views expressed by the authors do not necessarily reflect those of the American Dental Association, and Truven Health MarketScan is not responsible for the conduct of the research or for any of the opinions expressed in this article. The authors declare no conflicts of interest.

http://dx.doi.org10.1016/j.jpeds.2016.11.045

federal marketplaces use a single medical/dental deductible.[3] Under most of these plans, preventive services have first-dollar coverage and are exempt from the deductible. Many other dental care services, such as orthodontia, however, are not exempt.

In this study, we examine the financial implications of obtaining children's dental coverage through medical plans compared with SADPs, simulate total financial outlays for various patient profiles, and discuss policy implications of our findings.

Methods

We collected medical plan and SADP data for the 2015 plan year from the Center for Consumer Information and Insurance Oversight (CCIIO)[9,10] and Data.HealthCare.Gov.[11] We collected data for 31 of the 37 states operating through the FFM in 2015. We restricted our analysis to states that offered medical plans with embedded child dental coverage (embedded plans), medical plans without child dental coverage (unembedded plans), and SADPs (**Appendix**; available at www.jpeds.com). There are 6 FFM states that do not meet these criteria and were excluded from our analysis.

For each plan, we first assessed which of the 4 dental service categories were covered for children: preventive and diagnostic (ie, "check-up"), basic, major, and orthodontia. We then categorized 4 cost-sharing variables within each service category: deductible, out-of-pocket maximum, copayment, and coinsurance. These variables have specific values for each of the 4 categories of dental services, with spending applied first toward the deductible, when applicable, and then to applicable cost-sharing variables if a balance in total spending on a particular service category remains and the out-of-pocket maximum has not been reached. (If the plan's copayment amount is greater than a patient profile's spending amount in a given service category, we use the copayment amount in full. For example, if the patient profile's basic category spending amount was $5, but the copayment amount was $10, we used the full $10 copayment.) Once a plan's out-of-pocket maximum is reached, all additional dental services used in that plan year are considered as covered free of charge as long as the service falls under a category covered by the plan.

We matched data from the CCIIO and Data.HealthCare.Gov data sets by a common variable included in both data sets: Plan ID. We drew deductible applicability, copayment amounts, and coinsurance amounts from CCIIO. In some cases, the copayment or coinsurance variables contradict the deductible variable. (For example, the deductible variable may indicate that the deductible does not need to be met before cost-sharing for a specific service category begins, but the copayment or coinsurance variable may indicate the opposite.) We consequently used the information from the copayment or coinsurance variables instead of the deductible variable, which in our view, is a more conservative approach.

We drew deductible amounts and out-of-pocket maximum amounts from Data.HealthCare.Gov for both embedded plans and SADPs. Some embedded plans had a separate dental deductible and out-of-pocket maximum. We conducted 2 levels of review to determine which embedded plans have separate deductibles and out-of-pocket maximums for child dental coverage. First, we reviewed each embedded plan's statement of benefits and coverage and each plan brochure for information on separate deductibles and out-of-pocket maximums for dental services. Second, when we could not find conclusive information through plan documentation, we contacted insurance company personnel directly.

To estimate children's dental care use patterns, we use "patient profiles" from previous research. Ideally, we would use data on dental care use and spending under medical and dental plans obtained through the FFM, but these data are not yet available publicly. We thus relied on previously published research on dental care use among children with private dental coverage[12] to categorize children into distinct patient profiles based on age group and dental spending level. Age groups include 1-6, 7-12, and 13-18 years as well as a combined category for aged 1-18 years. Dental spending levels were grouped into quartiles, plus an additional category of "no dental care use" for those with no dental care use and an additional category of "all," which averages across all beneficiaries.

Average annual dental spending for each of the patient profiles was estimated by multiplying the average use rate for each procedure by a fee. In most cases, the total amount paid to providers was used as the fee. For cases in which a dental procedure was not covered by a plan, the market rate was substituted as the fee as there is no payment to providers from the dental plan.

We estimate out-of-pocket spending and premium payments for our different patient profiles under every child dental coverage option available in the 31 FFM states we analyzed. We report results for all ages combined (ie, 1-18 years of age), but results for specific age subgroups (1-6, 7-12, and 13-18 years of age) are available on request. It is important to note, however, that the main conclusions from our analysis do not vary substantially by age subgroups.

We report results for each dental spending quartile as well as for children with no dental care use at all. We do this because 28.8% of children with private dental coverage do not have any dental claims within the year.[12] We also report results for all children combined.

Because embedded plans often have a single medical and dental deductible, we must make assumptions regarding patient spending toward deductibles stemming from medical care use. We take an extremely simple approach based on 2 scenarios: the deductible is fully reached before the use of any dental care services, or the deductible is not fully reached.

We focus on 12 patient profiles in our analysis: 6 levels of dental care use (no dental care use, quartiles 1 through 4, and "all," which is an average across all children regardless of use) and the 2 deductible scenarios. We estimated the monthly premium cost for embedded plans, unembedded plans, and SADPs by averaging each plan's monthly premium across rating areas. We annualize all premium amounts by multiplying the monthly amount by 12.

We then estimate out-of-pocket spending for each patient profile under every dental coverage option available. The