





Dental insurance: Plans without protections

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Why dental plans should be regulated like health plans to protect consumers and employers

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INTRODUCTION

The Affordable Care Act (ACA) instituted new regulations on health insurance plans. One of the biggest changes was that large health plans are now required to spend 85% of health insurance premiums on health care services and smaller and individual health plans are required to spend 80%. The remaining 15%-20% of premium revenues can be used for administrative costs and profits. These so-called Medical Loss Ratio (MLR) rules require that plans return excess premium revenues as rebates to beneficiaries.

In a year like we just had, where consumption changed dramatically from what health insurance actuaries predicted, MLR rebates protect consumers. Health insurers are returning \$2.1 billion in MLR rebates in 2021 because people used fewer health care services in 2020 than had been anticipated and priced into premiums.¹

But dental insurance plans were exempt from ACA reforms and are not subject to these MLR rules. Some dental health plans have spent as little as 4% of premiums on actual dental care.² Additionally, they typically have annual maximum benefit limitations and high cost-sharing. All and all, patients often get a bad deal on dental health plans.

Last year, spending on dental services dropped 20%.³ But most consumers and employers won't see that money returned to them through rebates. Instead, it will line the pockets of dental insurance companies as a nice windfall.

But if we wouldn't let health plans keep the excess premiums, why do we continue to let dental health plans go unchecked? This brief outlines why it's important to subject dental health plans to the same regulations as medical health insurance.

BACKGROUND

It's an accident of history that oral health is treated separately from our medical system. When early dentists wanted to join the Medical College at the University of Maryland, the physicians refused them entry. Dentists set up their own line of study and that divide lives on. Fewer than 1% of health plans include dental benefits — usually dental health plans are purchased separately, often from a different company — to fill in what health plans leave out.⁴

Roughly 80% of Americans have some form of dental coverage.⁵ Of those with coverage, roughly two-thirds have private dental coverage, usually offered by an employer, though about 7% of Americans buy stand-alone dental plans through or outside of the ACA exchanges.⁶ Of those with private coverage, 77 million are in self-insured plans that are governed by the federal government and 88 million are in plans that are regulated by the states.⁷ The remaining third have publicly funded coverage through Medicaid, CHIP, TriCare, or Medicare Advantage.

But even those who have employer-sponsored dental coverage often don't get a great deal. A typical dental insurance plan offers what is known as "100-80-50" coverage. This means the plan will pay 100% of the cost of routine preventive cleanings. Then it will cover 80% of the cost of basic services such as fillings or root canals, and 50% of the cost of major procedures such as crowns and bridges. Usually there is a maximum benefit of \$1,000-\$2,000 per year. While only 6% of people exceed their maximum benefit per year, requiring one crown can cost over \$2,000 — blowing through the maximum benefit.⁸

Dental costs have been increasing for decades. Between 1996 and 2016, per capita dental care expenditures increased 27%.⁹ Expenditures for dental services increased from \$43 billion in 1996 to \$96 billion in 2015 — a 200% increase.¹⁰ In 1996, the mean annual expense for a dental visit was \$374, or \$564 when adjusted for inflation, but by 2015, that had increased to \$696. But the average dental plan benefit has not changed in 50 years. In 1970, a \$1,000 benefit was worth about \$6,909 in 2021 dollars.¹¹ Yet, some plans still have a \$1,000 maximum benefit in 2021 which no longer provides the same level of coverage because of inflation.

How dental health plans are regulated

Of the 260 million Americans with dental health insurance in the U.S., roughly 47% of privately insured individuals are in a so called "self-insured" plan regulated through the Employee Retirement Income Security Act of 1974 (ERISA) by the federal government.¹² The remaining 53% are in plans that are regulated by the states.

In some ways, dental benefits are like regular health insurance plans. Employers can pay for dental health plans with pre-tax dollars and consumers can use pre-tax Health Savings Accounts (HSAs) and Flexible Savings Accounts (FSAs) to pay for their out-of-pocket expenses.

But in other ways, they are treated differently. At the federal level dental plans are considered "excepted benefits" like vision and hearing. These types of benefits are only subject to MLR requirements at the federal level when dental benefits are embedded in the health plan,¹³ which is fewer than 1% of health plans. Otherwise, they are not subject to the same rules and regulations that other types of insurance plans are. They can deny coverage because of pre-existing

conditions (including a single missing tooth), and in-state annual and lifetime maximums, which are often quite low, and keep premiums as profits rather than spending them on dental health services.

States also have oversight authority over dental plans that aren't regulated at the federal level. Some states have passed transparency rules requiring dental health plans to show how much they spend on dental services each year — and the data are concerning. One study of California dental plans found that plans spent as little as 4% of their premiums on dental health services.¹⁴ While the average was much higher (76%), there is plenty of opportunity to better standardize dental plans to protect consumers and the employers paying for their benefits.

Under the ACA, health insurers are required to have an 80% medical loss ratio (MLR), meaning that they spend 80 cents out of every dollar on paying customers' claims and items that improve the quality of care. The ACA did not require the same for dental insurers, however, leaving them free to spend premium dollars they take in as they see fit.

However, because dental plans are not subject to these same rules, people are not getting rebates for the 20% decline in dental health services spending in 2020.¹⁵ Even now, well into 2021, Altarum's monthly Health Sector Economic Indicators (HSEI) found that recovery in spending on dental services has lagged all other health care spending categories and remains 17% below its January 2020 level.¹⁶ If there were MLR rules in place, people would be receiving rebates for the unused premium dollars. But instead, insurance companies can pocket the extra revenue.

There is a small portion of dental health plans sold through the ACA health insurance marketplace each year. Of the approximately 11.4 million consumers with an exchange plan in 2020, only 1.76 million purchased a stand-alone dental plan on the exchange.¹⁷ Dental plans offered on the marketplace are governed by a set of standardized rules. For example, an ACA-compliant dental coverage must offer a guaranteed "actuarial value" of either 70% or 85%. Actuarial value refers to the portion of covered services paid by the dental carrier relative to the patient's copayments and deductibles. Additionally, pediatric dental plans have an out-of-pocket maximum like health insurance. For pediatric dental health plans offered on the exchanges, the maximum out-of-pocket cannot exceed \$350 for one child, or \$700 for two or more children on the same policy.¹⁸ While only a small percent of Americans are enrolled in these types of plans, they demonstrate that including an out-of-pocket maximum to protect consumers does not make a dental plan prohibitively expensive, even without subsidies.

However, plans offered for adults are not required to cap out-of-pocket spending for dental health services unless the insured happens to have one of the very few health insurance plans that embed adult dental coverage.

Annual maximum vs. out-of-pocket maximum

While they sound similar, an annual maximum benefit couldn't be more different than an out-of-pocket maximum. An annual maximum benefit is a cap on how much a health plan will pay out over a year. Typically, dental plans set annual maximum benefits at \$1,000-\$2,000 per year. An out-of-pocket maximum caps the amount the beneficiary of a plan will have to pay each year. For dental plans, children usually have an out-of-pocket maximum for their dental health care, while adults do not.

What should change

Dental plans should be subject to greater regulation to ensure that consumers' and employers' dollars are going toward actual dental care. Federal policymakers should use their authority to better enforce consistent coverage through ERISA-regulated plans and the health insurance marketplace.

Federal action

States do not have the authority to regulate self-insured plans overseen by the federal government. Because almost half of those with dental health coverage are in these types of plans, it is up to the federal government to standardize what types of plans should be eligible to be purchased with pre-tax dollars. If the government is essentially subsidizing these plans, they should have to abide by the same regulations as other health insurance products.

- All dental health plans should be subject to the same MLR rules that health plans are. If plans spend less than 80% of premiums on dental health services, they should be required to return the excess as rebates.

- All dental health plans should have an out-of-pocket maximum to protect beneficiaries from very high, unexpected dental costs.
- Get rid of annual or lifetime benefit limits so dental health plans are more like medical health plans.
- All dental health plans should be subject to the same transparency rules that other health insurance products are.
- Adult dental health plans offered on the exchanges should be subject to the same rules as pediatric plans offered on the exchanges.

State action

Because federal action can often be slow and incremental, states can help make the case for some of these changes. First, states could require increased transparency of dental health plans. It wasn't until California required dental plans to release their data that it became clear that some plans were spending much more of the premiums they collected on care than other plans. Making this data public could help employers make informed decisions and encourage improvement from low performing plans.

Secondly, some states could implement similar reforms that the ACA required of all health plans. They could implement consumer protections like MLR rules and out-of-pocket maximums. While this would create more of a patchwork-like system for dental health plan regulation, if it proved successful, it could help push the federal government to act.

Dental plans should be subject to many of the same rules that other health insurance products are. These types of changes would better standardize dental health plans to protect consumers. Instating an annual out-of-

pocket max would shift the financial risk from consumers to dental health plans. And while they may need to restructure their benefits to account for the increased risk, premiums should not have to increase dramatically to cover the roughly 6% of beneficiaries that reach the cap each year.¹⁹ Subjecting dental health plans to MLR rules, however, would limit the amount of profit plans could make from the premiums of their beneficiaries.

Trade-offs

A plan that only spends 4% of premiums on dental services should not be allowed to call itself a dental health plan. However, when considering potential reforms, it's important to bear in mind how they might impact the market overall. One issue with MLRs in the health insurance industry is that they may have a perverse incentive on health care costs. Take, for example, a health insurance plan that collects \$100 in premiums. Under MLR rules, it is required to spend \$80 on health care and can keep \$20 for administrative costs and profit. If the same plan covering the same number of people collects \$200 in premiums and spends \$160 on health care services, it can keep \$40 for administrative costs and profit. This creates a perverse incentive to pay hospitals and providers more because if the overall pie is larger, their share will be larger.

Currently those price incentives do not exist in the dental market. There are more traditional incentives where dental plans are trying to pay dentists the lowest amount they will accept so that they can get their patients care and keep a chunk of the premiums as profit. One could also make an argument that dental service prices have not increased as fast as other types of health care service prices because the coverage is less generous. When consumers have a 50%

copay for bridges or crowns, they will be more sensitive to the price. If you make dental health plans more like traditional health insurance where consumers don't see the true cost of care, it's possible that this will apply upward pressure to prices and expenditures.

With any changes to the market, it will be important to monitor to make sure that it doesn't create perverse incentives that increase costs for the health care system and health care consumers.

CONCLUSION

It is important to acknowledge the trade-offs and potential risks of policy change. But currently most dental health plans are purchased with pre-tax dollars and yet, despite receiving what amounts to a very generous government subsidy, they are subject to very little oversight. The ACA standardized insurance across many markets – limiting what could be defined as a health insurance plan and protecting consumers and employers by ensuring that the majority of health insurance premiums were spent on health care services. It's time that dental health plans were subject to similar regulations. Premiums should be spent on dental services, consumers should be protected against unexpected expenses, and the data on where revenues end up should be released annually. This would bring to light for consumers, employers, and government purchasers the true value of dental health plans.

ABOUT THE AUTHOR

Arielle Kane the director of Health Policy at the Progressive Policy Institute. Her research focuses on what comes next for health policy in order to expand access, reduce costs and improve quality.

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