Dental Insurance in California:
Scope, Structure, and Availability

California HealthCare Foundation

ISSUE BRIEF

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Introduction

Like health insurance, dental insurance matters. Dental coverage directly affects a person's ability to obtain care because it reduces or removes financial barriers to services. However, unlike health insurance, there is a much smaller risk of catastrophic financial loss in the absence of dental insurance. This may be the primary reason for differences in coverage and scope of benefits between dental and health insurance.

Dental insurance is structured similarly to health insurance but often is more limited in scope and availability. People without dental insurance typically seek dental care less often and may suffer poor dental health as a consequence.

This issue brief examines the basic structure of dental insurance to illustrate how it enables Californians' access to dental care.

Coverage Overview

The extent of dental insurance coverage in the United States is substantially lower than that for health insurance. Nationally, 35 percent of the U.S. population has no dental coverage, compared with 15 percent without health insurance.[1] In California, 39 percent of the population has no dental coverage; 13 percent is without health insurance.[2]

Lack of dental insurance is associated with lower likelihood of a dental visit in a given year, regardless of income, race and ethnicity, employment, education level, and gender.[3] In other words, dental insurance enables people of different socioeconomic backgrounds to obtain dental services. However, this enabling effect may vary for people with different socioeconomic backgrounds.

Those without dental insurance coverage bear the entire cost of their dental services. Paying for dental care must compete with health care, food, rent, and other basic necessities, particularly for poor and disadvantaged people. In these contests, dental care often loses.

Private and Public Dental Insurance

Individuals can obtain dental insurance through benefits offered by their employers, purchase it privately, or qualify for public programs. Rate of coverage, cost-sharing, and scope of dental benefits vary with each type of coverage.

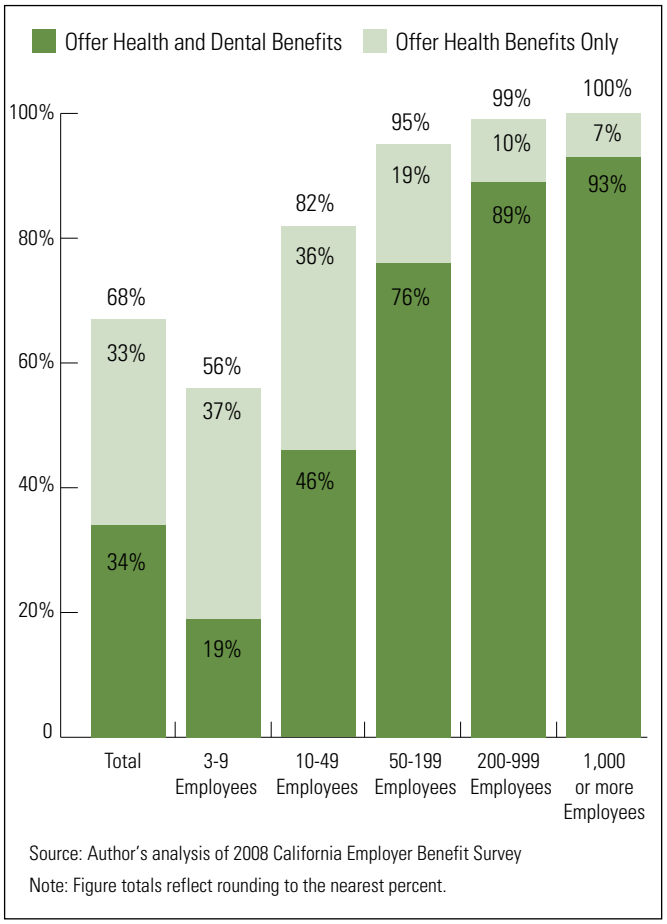
Employment-based Dental Insurance

Among Californians with dental insurance coverage, the great majority (78 percent) have employment-based coverage.[4]

Approximately 68 percent of California firms offer health insurance to their employees, but only 34 percent also offer dental benefits (see Figure 1 on page 2).[5] Larger employers are more likely to offer dental benefits. The highest offer rates are among firms with 1,000 or more employees.

People who are offered dental insurance tend to accept it. Although data on acceptance rates of employer-sponsored dental insurance are not available, data are available on health insurance acceptance rates. Dental benefits are rarely offered independently of health benefits. Therefore, offer and acceptance rates of health benefits among people with and without dental insurance may indicate patterns in dental insurance acceptance rates.

Figure 1: Health and Dental Benefit Offer Rates Among California Private Employers, 2008

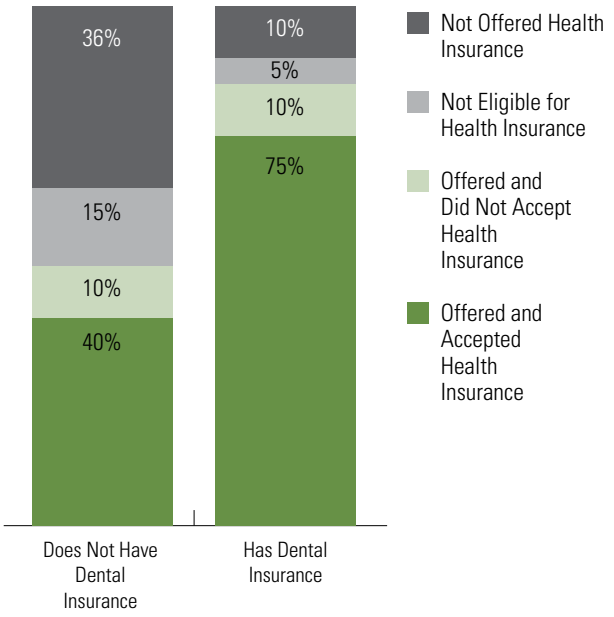


Source: Author's analysis of 2008 California Employer Benefit Survey

Note: Figure totals reflect rounding to the nearest percent.

Most people offered health insurance accept coverage. Many people with dental insurance were also offered employer-sponsored health benefits (75 percent). But fewer individuals without dental insurance were offered health coverage (40 percent) (Figure 2).[6]

Figure 2. Dental Insurance Coverage by Offer and Acceptance of Health Insurance, California, 2007



Source: Author's analysis of 2007 California Health Interview Survey

Note: Figure totals reflect rounding to the nearest percent.

Privately Purchased Dental Insurance

An estimated 5 percent of Californians have privately purchased dental insurance.[7] These are primarily people whose employers do not offer dental benefits and who do not qualify for public programs, most likely due to exceeding income eligibility requirements. Individual policies may vary greatly in their scope of benefits and restrictions.

Public Dental Insurance

As of 2007, about 17 percent of Californians were insured through public programs, some of which extend dental benefits to low-income people.[8] Those eligible for these programs include low-income workers who are not offered health and dental benefits, self-employed people, the unemployed, and those not in the labor market.

The vast majority of publicly insured adults in California receive dental coverage through Denti-Cal, which is available to low-income adults receiving full-scope benefits through Medi-Cal. The program does not require

significant copayments and providers have the option of forgoing copayments.[9]

The budget crisis in California has led to the elimination of adult dental benefits in Medicaid, with a few exceptions.

In the absence of such public coverage, low-income uninsured Californians can access county-level dental services under the safety-net system. But such programs often provide urgent and sporadic care for acute conditions rather than full dental insurance coverage.[10]

Other public forms of adult dental coverage include: Tricare for military personnel and their families; Veterans Affairs for veterans and their dependents; and Indian Health Services for federally recognized American Indians living on reservations. These programs constitute a very small share of the publicly insured market.

Among retirees and those age 65 and older, Medicare does not provide dental benefits outside of specific services such as jaw reconstruction after an accident, extractions prior to radiation treatment, or oral examination prior to kidney transplantation or heart valve replacement.[11] However, Medicare Advantage (Medicare HMO) plans do offer dental benefits to approximately 33 percent of participants.[12]

Types of Dental Insurance

Dental insurance plans, much like health insurance plans, can be divided into HMOs, PPOs, and traditional indemnity plans. Discount/referral plans and direct reimbursement plans also have a presence in this market.

Dental HMOs

Dental HMO (DHMO) plans have a smaller market share in California than HMOs. Approximately 50 percent of Californians are enrolled in HMOs,[13] while only about 10 percent are enrolled in DHMOs. California leads other states with an estimated 3.5 million people enrolled in DHMOs.[14] Forty-two percent of Medi-Cal recipients are enrolled in HMOs while only 4 percent of Denti-Cal recipients are enrolled in DHMOs.[15]

The small market share of DHMOs compared with other dental plans is partly due to the structure of these plans. DHMOs provide dental benefits on a capitation basis using a contracted provider network. Some DHMOs may allow consumers to use non-network providers on a fee-for-service basis. DHMOs rely on primary care dentists to perform gatekeeper functions, including referrals to specialists. Some DHMOs may allow self-referrals, though the primary care dentist may be ultimately responsible if such referrals are deemed unnecessary.

DHMO participants can face both limitations in their choice of dental providers and significant levels of utilization review when accessing dental services. While DHMOs have lower levels of cost-sharing compared with other dental plan types, they pay on a capitation basis, which may lead to lower provider participation. Data from a 2003 survey of California dentists in private practice confirmed that just 5 percent of their gross practice income was from DHMOs, in contrast with 55 percent from non-HMO private dental insurance.[16] Employers generally perceive DHMOs as limiting the choice and quality of available dentists and most often offer them as one option among other types of plans.[17]

Dental PPOs

Dental PPOs (DPPOs) have increased their market share since 2000.[18] Nationally, approximately 63 percent of dental subscribers were enrolled in dental PPO plans as of 2007. California has the largest number of DPPO participants in the United States: an estimated 12.4 million, or 34 percent of the state's population.[19] This comparatively large share of the market is partly attributed to PPO features such as payment method, provider network size, and amount of utilization review. Employers may choose DPPOs to reduce costs while offering benefit and provider access levels similar to indemnity plans.

The more popular PPO dental plans utilize large networks of preferred providers who agree to discounted reimbursement amounts. Although some utilization review may be required of these providers, it tends to be more limited than that of DHMOs. Utilization review within dental PPOs may include retrospective review of provider billing and practice patterns as well as pre-authorization for some major services.

Dental Indemnity, Discount, and Direct Reimbursement Plans

Other types of plans in the national dental insurance market include indemnity, discount, and direct reimbursement plans.

Dental indemnity plans have 17 percent of the market share. In California, 7.3 percent of the population is insured under this type of plan.[20] These plans pay providers on a fee-for-service basis without any discounts or contractual arrangements. Nationally, dental indemnity plans may also include some level of utilization review and restrictions on choice of providers. In general, they are a slowly declining presence.[21]

Dental discount plans (also called referral plans) have about 10 percent of the market share nationally[22] and 0.3 percent in California. Dental discount plans are more prevalent in the individual market than other types of plans. Nineteen percent of discount plan participants are covered by individual policies. In contrast, 3 percent of DHMOs and 1 percent of DPPOs and dental indemnity participants are covered by individual policies.[23] A dental discount plan is a non-insured arrangement in which a panel of providers agrees to discounted fees directly paid by participants. Discount plans do not contribute to the cost of services.

Direct reimbursement plans have 1 percent of the national market share. They function similarly to employment-based health saving accounts without a health plan feature. These self-funded programs reimburse participants for a percentage of their dental care expenditures and do not impose any restrictions on the choice of providers.

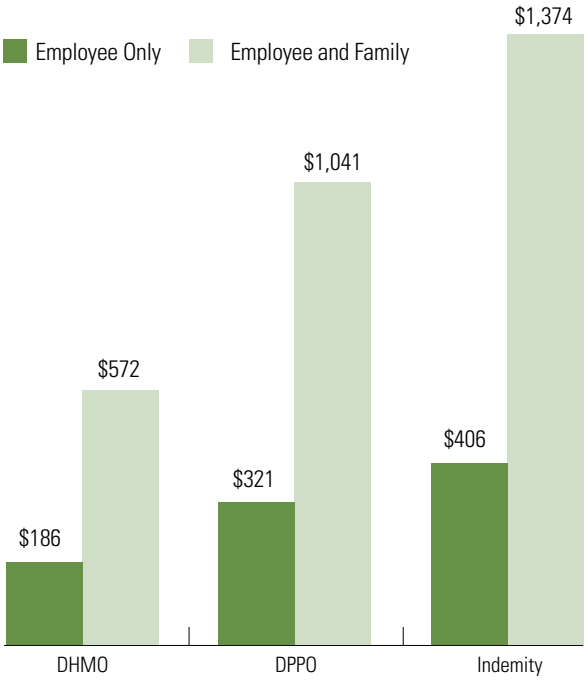
Dental Insurance Premiums and Effect on Plan Acceptance

Premiums vary by plan type. Among the most prevalent plans in the group market, DHMOs have the lowest annual premiums nationally and indemnity plans have the highest (Figure 3). Lower-premium plans that exclude services such as orthodontia can cost as little as $183 for DHMOs and $350 for indemnity plans for employee-only plans. Estimated annual premiums for discount plans, more common in the individual market, range from $132 for an individual to $300 for a family.

In employment-based plans, the employee may pay the entire premium, some of it, or none of it. Contribution rates vary by type of plan. For example, 26 percent of DHMO participants pay the entire premium, followed by 14 percent of DPPO participants, 16 percent of dental indemnity participants, and 10 percent of discount plan participants.[24]

There is a direct correlation between employer premium contribution and employee acceptance of dental benefits. When employers pay the entire premium, over 90 percent of employees participate. When employers pay part of the premium, 70 percent of employees participate.[25]

Figure 3. Annual Premium Amounts for Plans with Orthodontia Benefits in Private Group Market, by Type of Plan



Source: 2007 NADP Dental Benefits Report: Premium Trends.

Scope of Benefits and Cost-Sharing

Dental benefits are generally divided into three types: preventive/diagnostic (e.g., cleaning, routine dental exams); basic care and procedures (e.g., fillings, extractions); and major dental care (e.g., root canals, crowns).[26] Orthodontia, cosmetic, and implants are other categories of services. Dental implants and cosmetic care are generally excluded from benefits. The bulk of dental services delivered are low-cost, such as routine dental exams.[27]

Cost-sharing for dental health benefits in the private market is structured similarly to general health benefits, with tiered deductibles and cost-sharing depending on the type of service. However, the scope of covered benefits and out-of-pocket expenditures differ considerably from plan to plan. DHMOs do not include deductibles and have low co-pays. PPOs and indemnity plans cover preventive care without applying deductibles. Beyond preventive services, tiered deductibles and cost-sharing levels are applied. Services such as fillings and extractions have lower deductibles and cost-sharing amounts, while major services such as crowns and root canals require higher deductibles and contributions. Among employment-based plans, the most common deductibles are $50 and 20 percent cost-sharing for basic services. For major services, the same deductibles and 50 percent cost-sharing are most common.[28] When orthodontic services are available to adults, they are covered at higher cost-sharing levels and sometimes as a flat amount regardless of overall costs.

Many dental plans have an annual cap for covered services, at which point the plan stops contributing to the cost of services until the next enrollment year. Of the plans:

- DHMOs do not have a cap;
- The majority of indemnity (65 percent) and PPO (57 percent) plans have a cap with a national median of $1,000 to $1,500. Caps of $1,500 to 1,999 are less common; only 21 percent of indemnity and 30 percent of PPO plans apply these caps. Small percentages have higher annual caps;[29] and
- Denti-Cal's annual cap is $1,800.[30]

Restrictions on utilization, such as waiting times before covering services, are less common in employment-based plans and not applicable to public dental coverage. Other limitations and exclusions may include time limitations on crowns and bridges and congenital conditions. However, the level of benefits may increase after the first year and subsequent years of maintaining the policy as a reward to policyholders.

Summary and Conclusions

Although dental insurance is structured similarly to health insurance, it is often more limited in scope and availability, primarily because many employers do not offer dental benefits. Consequently, dental insurance plays a more limited role in dental service utilization.

Unlike health insurance, PPOs and indemnity plans dominate the private dental insurance market. Dental insurance plans may employ utilization review and management in HMO, PPO, and indemnity plans. In the public market, extensive authorization requirements are also employed to control service utilization.

Coverage limitations and variable levels of cost-sharing may lead to significant out-of-pocket expenditures for people with dental insurance. The level of out-of-pocket expenditures for each individual corresponds to the level of need for dental care, actual dental care use, and ability to pay for costs that are not covered by dental policies.

Economic downturns threaten dental insurance coverage rates as employers seek cost-saving measures. Although the number of employers that offer dental benefits has remained relatively stable since 2003,[31] these numbers may change as the economic climate worsens.

Small firms have lower offer rates than large firms because small firms often have lower financial reserves and are more likely to reduce benefits to save costs. In California, small firms are frequently concentrated within the retail and service industries and employ a larger share of lower-income people. Losses in dental benefits in this market have a disproportionate effect on vulnerable populations who do not have the financial means to purchase private dental insurance.

Furthermore, those seeking private dental insurance do not have the negotiating power of an employer, which contributes to holding down the level of benefits offered.

The trend toward increased market share of dental PPO plans in the private market can potentially shift a greater share of dental expenditures to the insured population. While PPO plans may offer a greater choice of providers, the higher level of cost-sharing is very likely to increase disparities in service utilization between those of lower socioeconomic status and the better-off.

Likewise, new plan designs, such as low-premium, high-deductible dental plans, have the potential to further foster disparities, since they may appeal to lower-income populations. Yet high deductibles can lead to further delays of less urgent basic services, allowing problems such as cavities to escalate into more serious conditions that require more expensive procedures, such as crowns and root canals.

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About the Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information about CHCF, visit www.chcf.org.

Endnotes

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