

Key Findings:

Analysis of California Assembly Bill 2643

Dentistry: General Anesthesia

Summary to the 2017–2018 California State Legislature, April 16, 2018



AT A GLANCE

The version of California Assembly Bill (AB) 2643 analyzed by CHBRP would remove location specificity of where health insurance plans and policies would be required to cover dental general anesthesia (DGA) for specified populations and would add the phrase “including nonsurgical treatment options” to the existing required consent form language for DGA when provided to minors.

1. CHBRP estimates that, in 2019, of the 23.4 million Californians enrolled in state-regulated health insurance, 100% of them will have insurance subject to AB 2643.
2. **Benefit coverage.** Benefit coverage of DGA that takes place in any location would increase from 6% of enrollees premandate to 100% of enrollees postmandate. AB 2643 is not expected to exceed the definition of essential health benefits (EHBs).
3. **Utilization.** A total of 124,000 enrollees currently utilize DGA in any location. In the first year postmandate, utilization of DGA in a dental office will remain the same due to supply constraints, but that the utilization will shift from being covered through out-of-pocket expenditures or Denti-Cal, to being covered through Department of Managed Health Care (DMHC)-regulated plans or California Department of Insurance (CDI)-regulated policies.
4. **Expenditures.** AB 2643 would increase total net annual expenditures by \$42,819,000 (0.0275%) for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an \$80,413,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a decrease of \$37,594,000 in enrollee expenses for covered and/or noncovered benefits.
5. **Medical effectiveness.**
 - a. Limited evidence that procedures involving DGA in office-based settings are not any less safe and effective than those provided in hospitals or surgery centers.

AT A GLANCE, Cont.

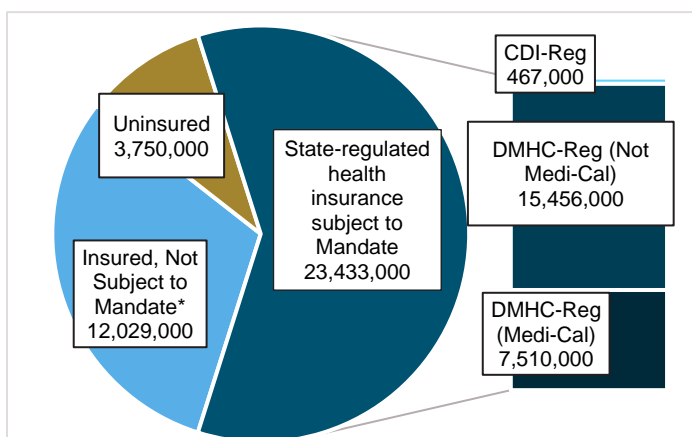
- b. A preponderance of evidence that lack of treatment for conditions such as dental caries can lead to secondary complications that could impact dental and overall health.
 - c. Limited evidence that informed consent forms are not thoroughly read or understood by parents/caregivers of pediatric patients or patients with special needs.
 - d. Insufficient evidence that the addition of new wording to the informed consent form would impact patient choice of treatment or service utilization.
6. **Public health.** There will be no short-term public health impacts from AB 2643. However, there will be a reduction in financial burden on enrollees who would have paid for noncovered DGA out-of-pocket premandate and would obtain DGA as a covered benefit postmandate.
 7. **Long-term impacts.** CHBRP estimates that utilization of DGA will remain similar to the one-year postmandate estimates of 2019, given the provider constraints on supply of DGA. However, the postmandate coverage under AB 2643 may encourage more dental providers to become licensed in DGA and to perform the service in a dental office, which would loosen the supply constraints. Despite a stable reduction in financial burden, there will be no long-term public health impacts.

BILL SUMMARY

Health insurance plans and policies are currently required to cover dental general anesthesia (DGA) performed in a hospital or surgical center for enrollees whose health is compromised and for whom general anesthesia is medically necessary (regardless of age), enrollees who are developmentally disabled (regardless of age), or enrollees under age seven. AB 2643 would remove location specificity of where health insurance plans and policies would be required to cover DGA for these populations. AB 2643 would also modify existing code by

adding the phrase “including nonsurgical treatment options” to the existing required consent form language for DGA when provided to minors encouraging patients to explore all other treatment options. Figure 1 notes how many Californians have health insurance that would be subject to AB 2643.

Figure 1. Health Insurance in CA and AB 2643



Source: California Health Benefit Review Program, 2018.

Notes: * Such as enrollees in Medicare, Medi-Cal not regulated by DMHC, and self-insured products.

CONTEXT

While all health insurance plans and policies regulated by DMHC or CDI would be impacted by AB 2643, only enrollees who meet the specified criteria in current law would be eligible for newly covered DGA services. These three categories of enrollees are not mutually exclusive (i.e. a child under seven years of age could also have a developmental disability), but enrollees only need to meet one criteria to be eligible for DGA as a covered medical benefit. CHBRP estimates approximately 10 million enrollees may meet specified criteria included in AB 2643, however, only a very small portion of this population requires general anesthesia for dental procedures.¹

CHBRP assumes the number of dentists providing general anesthesia remains constant in the first year post implementation of AB 2643 because the amount of time required to meet the education components is at least one year. CHBRP also assumes that providers of DGA services are at capacity and are not able to increase the number of DGA services performed. Therefore, utilization

¹ Refer to CHBRP’s full report for full citations and references.

of DGA is unable to increase within the first year post implementation of AB 2643.

An estimated 50% of around 500 board-certified pediatric dentists provide DGA and/or sedation in their offices in California. Dentists who deem DGA necessary for a patient may refer that individual for care within a surgical center or hospital if appropriate for the patient’s condition or if they do not offer general anesthesia within their office.

Children under age seven years or adults with special needs may require DGA due to (1) advanced oral conditions requiring extensive surgical intervention that cannot be done with lighter forms of sedation or local anesthetic, (2) when the patient is allergic to local anesthetics, and (3) when the dentist determines that the patient is unable to undergo any dental procedure that requires them to remain still so that the dentist can perform the procedure without injuring the patient, even with lighter forms of sedation.

IMPACTS

Benefit Coverage, Utilization, and Cost

CHBRP assumes that the annual utilization of DGA cannot increase given their current capacity, workload and time constraints. CHBRP assumes that there will be no shift from hospital or surgical centers to dental offices in total utilization of DGA, as the current relative prevalence of procedures is already weighted strongly towards the dental office, even in the absence of coverage.

Benefit Coverage

Currently, 6% of enrollees with health insurance that would be subject to AB 2643 have medical coverage for DGA that takes place in any location. Postmandate, CHBRP estimates that coverage will increase to 100% of enrollees in DMHC-regulated plans or CDI-regulated policies. This would increase the number of enrollees with coverage compliant with AB 2643 from 1.5 million at baseline to the full 23.4 million enrolled in DMHC-regulated plans or CDI-regulated policies, postmandate. However, the number of enrollees eligible for health insurance coverage of DGA is limited to the populations

stated above, and is therefore substantially smaller than 23.4 million enrollees.

Utilization

CHBRP estimates a total of 124,000 enrollees currently utilize DGA in any location. This population is comprised of 60,000 enrollees in Medi-Cal Managed Care plans and 64,000 enrollees in commercial plans and policies. During the first year postmandate, CHBRP estimates no increase in total utilization for all populations, based on provider supply constraints and that DGA is used in cases of medical necessity.

Currently, 0.37 per 1,000 enrollees in commercial plans or policies, and 1.45 per 1,000 enrollees in DMHC-regulated Medi-Cal Managed Care plans use DGA in a hospital or surgical center setting. CHBRP estimates that this prevalence rate will not change postmandate as AB 2643 does not increase coverage for general anesthesia for dental procedures in these locations.

Currently, there are 3.63 per 1,000 enrollees in commercial plans or policies, and 6.55 per 1,000 enrollees in Medi-Cal Managed Care plans that use DGA in dental offices, with limited health insurance coverage for these locations. While enrollees in commercial plans or policies pay for DGA in a dental office out of pocket, enrollees in Medi-Cal Managed Care plans have coverage for DGA through Denti-Cal. CHBRP estimates that in the first year postmandate, utilization of DGA in a dental office will remain the same due to supply constraints, but that the utilization will shift from being covered through out-of-pocket expenditures or Denti-Cal, to being covered through DMHC-regulated plans or CDI-regulated policies. Therefore, utilization covered through DMHC-regulated plans or CDI-regulated policies will increase postmandate by 3.63 per 1,000 enrollees in commercial plans or policies, and by 6.55 per 1,000 enrollees in Medi-Cal Managed Care Plans.

Expenditures

AB 2643 would increase total net annual expenditures by \$42,819,000, or 0.0275%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an \$80,413,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a decrease of \$37,594,000 in enrollee expenses for covered and/or noncovered benefits.

Premium increases in privately funded DMHC-regulated plans range from \$0.1835 per member per month (PMPM) for individual plans to \$0.2159 PMPM for large-group plans. Among CDI-regulated policies, premium increases range from \$0.0122 PMPM for large-group policies to \$0.1873 PMPM for individual policies. After offsetting decreases in enrollee expenses for noncovered benefits, premium increases in privately funded DMHC-regulated plans or CDI-regulated policies range from 0.0002% for CDI-regulated large-group policies to 0.0065% for CDI-regulated individual policies.

Medi-Cal

Expenditures paid for by Medi-Cal Managed Care plans are expected to increase by \$36,363,000, or 0.12%, in 2019. Although Medi-Cal enrollees do not pay premiums, per member per month “premiums” would increase by \$0.4035. As discussed above, since utilization is not expected to increase in the first year postmandate, costs for DGA are shifting from Denti-Cal to Medi-Cal Managed Care plans.

CalPERS

Expenditures for CalPERS are expected to increase by \$2,121,000 or 0.04% in 2019. Premiums are projected to increase by \$0.2317 PMPM.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 2643.

Medical Effectiveness

DGA

CHBRP found limited evidence that procedures involving DGA in office-based settings are not any less safe and effective than those provided in hospitals or surgery centers.

General anesthesia (as opposed to lesser levels of sedation) is more commonly used in youth and children for routine procedures, such as the treatment of dental caries, than in adults. This is also true for persons of all ages with special needs, such as mental or physical

disabilities, or those requiring DGA due to medical necessity. For these populations, the outcomes related to receiving dental surgery without DGA (safety issues, treatment efficacy) could potentially be affected.

Treatment under other forms of anesthesia that do not render the patient unresponsive to physical stimuli may not adequately control patient movement, or may require patient cooperation and adherence to instructions that is beyond the ability of young children or adults with special needs. CHBRP found inconclusive evidence that receiving dental surgery under conscious sedation versus DGA could affect outcomes.

Although there are numerous alternative treatments available for some routine dental procedures (such as preventative measures or routine cleanings) that may require no or minimal sedation for the general population, the literature review revealed no proven alternative options for the comprehensive treatment of most problems that require DGA (such as tooth infection or decay to the degree requiring extraction), especially for populations such as very young children or children and adults with special needs. CHBRP found insufficient evidence that there are effective alternate treatments for young children or special needs populations for which DGA or any type of sedation is not needed.

It is possible that in cases where coverage for DGA is not available in the dental office for required dental procedures, patients (or parents or caregivers of patients) may forgo care. CHBRP found a preponderance of evidence that lack of treatment for conditions such as dental caries can lead to secondary complications that could impact dental and overall health.

Informed Consent

Prior to administering DGA or performing other dental procedures on a child, parents or caregivers must be administered an informed consent document, meaning that the provider must explain the procedure, why it is recommended, and the benefits, and risks to parents so that they can decide whether or not to allow the child to be treated. There is limited evidence that informed consent forms are not thoroughly read or understood by parents/caregivers of pediatric patients or patients with special needs.

CHBRP found no studies examining the impact of new language to the informed consent form with regard to patient or caregiver/parent decision making, and therefore

concludes there is insufficient evidence to that the addition of new wording to the informed consent form would impact patient choice of treatment or service utilization.

Public Health

In the first year postmandate, because no change or shift in utilization is estimated, CHBRP estimates that coverage of DGA in office-based settings for pediatric and special needs populations will have no public health impact. However, there will be a reduction in financial burden on enrollees who would have paid for noncovered DGA out of pocket premandate and would obtain DGA as a covered benefit postmandate.

In the first year postmandate, there will be no public health impact of AB 2643 regarding adding text to the parental informed consent to explore nonsurgical treatment options on decisions about children receiving DGA due to insufficient evidence that changing the language would impact parents' decisions and consequently no estimated change in utilization or coverage.

Long-Term Impacts

Over the long term, CHBRP estimates that utilization of DGA will remain similar to the one-year postmandate estimates of 2019, given the provider constraints on supply of DGA. However, the postmandate coverage under AB 2643 may encourage more dental providers to become licensed in DGA and to perform the service in a dental office, which would loosen the supply constraints. While overall utilization of DGA would still be constrained by medical necessity, the current waitlists could be shortened, and more instances of DGA could occur within a one-year timeframe.

Despite a stable reduction in financial burden, there will be no long-term public health impacts. However, it stands to reason that given the increase in coverage, especially for privately insured enrollees, in the longer term as out-of-pocket costs are reduced, demand for DGA may increase, and more dental professionals may become DGA-certified and offer DGA at their office-based practices as they will now be able to be reimbursed for the service by insurance, increasing the supply of DGA professionals; the lack thereof is the limiting factor

preventing any forecasted increase or shift in DGA utilization over time.

Essential Health Benefits and the Affordable Care Act

Because AB 2643 amends the locations for which this service is covered, it would not require coverage for a new state benefit mandate and appears not to exceed the definition of essential health benefits in California.