



Abbreviated Analysis

California Assembly Bill 1048: Dental Benefits and Rate Review

Report to the 2023–2024
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SUMMARY

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)¹ conduct an evidence-based assessment of California Assembly Bill (AB) 1048. AB 1048 would prohibit a health insurer that covers dental services or specialized health care service plan or health insurer that covers dental services, from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or pre-existing condition provision, upon an enrollee or insured. The bill excludes Medi-Cal.

The bill would also require the Department of Managed Health Care and the Department of Insurance to establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a specialized health care service plan contract or specialized health insurance policy covering dental services is unreasonable, or not justified, under the applicable requirements of the rate review provisions under existing law.

Oral Health

Oral health includes many local and systemic issues that can affect the mouth and beyond. Oral health also encompasses the connective tissues, ligaments, and bone in or interfacing with the mouth and teeth as well as the nervous, immune, and vascular systems that affect the mouth. Various oral conditions such as infections, immune disorders, injuries, and cancers can affect functioning in other parts of the human body. Likewise, systemic conditions such as diabetes, high blood pressure, respiratory problems, and stroke can impact oral health.

Dental Spending

Although national rates of dental insurance remain lower than those of medical insurance, more than 26 million Americans have some form of dental coverage, with half receiving that coverage through their employer. Dental spending represents approximately 4% of total health care spending in California in 2020.

Dental Insurance in California

The majority of dental benefit plans are “fully insured” and regulated at the state level by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). The Affordable Care Act (ACA), helped California expand Medi-Cal eligibility and offer

dental benefits to newly eligible adult enrollees (the “expansion population”). Additionally, all Covered California health insurance plans offer embedded pediatric dental coverage at no extra cost (the cost of dental is embedded in the plan premiums). For adults, a dental plan can be added to health plan purchases.

Dental insurance commonly divides oral health services into the following categories: preventive and diagnostic, basic restorative services, major restorative services, and orthodontics.

Preventive and diagnostic services are typically the most generous in terms of coverage. Basic restorative services include the treatments for common dental problems and are generally straightforward and nonsurgical in nature, such as simple extractions and basic root canals. Major restorative services, however, are often complex or lengthy, typically requiring more time and expense than basic services. Coverage for major restorative services can be limited in many dental plan designs and products (even if plans do not have pre-existing condition exclusions or waiting periods).

Some plans and policies include pre-existing condition exclusions and waiting periods as part of the dental plan design, to address adverse selection. While pre-existing condition exclusions and waiting periods differ by plan, these conditions are typically applied to costlier dental services.

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

Oral Health Disparities

Oral health care typically presents the highest level of financial barrier (for why people don't seek dental care) compared with all other types of health care services, particularly for adults. However, health care costs exceed dental costs in general.

Racial disparities in dental care access have narrowed over the last decade for children, but Black and Hispanic children are still less likely to visit a dentist than White children. Additional barriers to care also remain, such as transportation, access to caregiving, and fear of dental treatment.

Policy Context

Twenty-eight states have not instituted adult dental coverage in their State Medicaid programs. However, all states (and territories) have always provided immediate coverage for dental treatment for eligible children.

While not directly applicable to AB 1048, a number of states in addition to California have considered the issue of medical loss ratio (MLR), which measures the share of a health care premium dollar spent on medical benefits, as opposed to company expenses such as overhead or profits. This relates to the transparency requirements included in AB 1048, intended to ensure that premium rates are justified and largely spent on dental medical claims. In 2013, the California Legislature considered requiring health insurers that offered pediatric dental coverage through the Covered California Marketplace to maintain a medical loss ratio of 75%. In 2014 California passed a law requiring dental insurance plans to file annual MLR reports. In 2018, SB 1008, proposed a minimum MLR of 70% for dental plans in the individual and small-group markets and 75% in the large-group market, but amendments removed these thresholds in May 2018.

Several states have been considering bills related to MLR. Maine recently enacted legislation eliminating waiting periods for children under age 19 years. Louisiana recently

passed a bill that would prohibit denial of claims based upon pre-existing conditions; but would authorize a 12-month waiting period for pre-existing conditions.

Medical Effectiveness

The medical effectiveness review summarizes findings from evidence on the impact of dental waiting periods, pre-existing condition provisions, delayed dental procedures, delayed dental disease treatment, and untreated dental disease on health outcomes. The generalizability of these studies to AB 1048 are limited.

CHBRP found insufficient evidence to determine whether the elimination of dental waiting period provisions impacts health outcomes.

CHBRP found insufficient evidence to determine whether the elimination of pre-existing condition provisions impacts health outcomes because CHBRP did not identify any studies on this topic. CHBRP also found that there is insufficient evidence to determine whether a delay in receiving basic or major dental procedures impacts health outcomes because CHBRP did not identify any studies on this topic.

There is insufficient evidence to determine whether a delay in caries treatment impacts health outcomes because CHBRP did not identify any studies on this topic. And CHBRP found that there is insufficient evidence to determine whether a delay in periodontal disease treatment impacts health outcomes because the studies identified are not generalizable to nonpregnant people and only assessed the impact of delaying treatment on birth outcomes. The absence of evidence is not evidence of no effect.

CHBRP found that there is limited evidence that untreated caries is associated with greater rates of dental pain in children. And CHBRP found a preponderance of evidence that untreated periodontal disease is associated with greater rates of probing depth, attachment loss, tooth loss, health care costs, hospitalizations, experiences of dental pain, discomfort, and dysfunction in regular activities in adults.

Benefit Coverage

10,947,000 Californians would be subject to AB 1048; 43% of the enrollees who are subject to AB 1048 have, at baseline, no waiting periods or pre-existing condition provisions.

Impacts and Expenditures

AB 1048 would increase total net annual expenditures by \$8,262,000, or 1.68%, in expenditures for enrollees with DMHC-regulated plans and CDI-regulated dental insurance policies. The impacts of AB 1048 vary by market. Postmandate, 100% of enrollees would be compliant with AB 1048.

Long-Term Utilization and Cost Impacts

Waiting periods and pre-existing condition limitations are tools employed by dental carriers to prevent adverse risk selection. Eliminating these provisions may result in enrollees lapsing their coverage and re-signing up as dental services are needed. With fewer enrollees not requiring dental services purchasing dental insurance, the cost of dental services would be spread across a smaller pool of enrollees, resulting in higher premiums.

POLICY CONTEXT

On February 21, 2023, The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP) conduct an evidence-based analysis of the impacts of Assembly Bill (AB) 1048: Dental Benefits and Rate Review. CHBRP focused on fiscal and policy analysis and conducted a limited medical effectiveness analysis.

Bill-Specific Analysis of AB 1048, Dental Benefits and Rate Review

Bill Language

AB 1048 prohibits a health insurer that covers dental services or specialized health care service plan or health insurer that covers dental services, from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or pre-existing condition provision, upon an enrollee or insured. The bill language exempts Medi-Cal dental managed care contracts authorized under Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

The bill would establish the following definitions:

- “Dental waiting period provision” means a contract provision that limits coverage for a specified period of time following an enrollee’s effective date of coverage.
- “Health care service plan” means a health care service plan that issues, sells, renews, or offers a plan contract covering dental services or a specialized health care service plans covering dental services.
- (3) “Preexisting condition provision” means a contract provision that excludes coverage for charges or expenses incurred during a specified period following an enrollee’s effective date of coverage, as to a condition for which dental advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.
- The bill would also require the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a specialized health care service plan contract or specialized health insurance policy covering dental services is unreasonable, or not justified, under the applicable requirements of the rate review provisions under existing law.

The full text of AB 1048 can be found in Appendix A.

Analytic Approach and Key Assumptions

AB 1048 applies to commercial individual and group dental plan enrollees. AB 1048 would not impact CalPERS enrollees based on a review of the plans’ benefit design for CalPERS.²

AB 1048 also requires the Department of Managed Health Care and the Department of Insurance to establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a specialized health care service plan contract or specialized health insurance policy covering dental services is unreasonable, or not justified, under the applicable requirements of the rate review provisions under existing law. CHBRP did not estimate the impact of imposing rate reviews on these policies.

² California Department of Human Resources. www.calhr.ca.gov/benefits/Documents/dental-handbook-2021.pdf.

At baseline, enrollees may experience delayed or untreated dental conditions due to waiting periods and pre-existing condition provisions. CHBRP did not measure the impact of potential savings resulting from timelier care.

Federal Policy

Significant disparity between child and adult dental service use exists due to federal and state governmental policymaking across the country. Comprehensive dental coverage is ensured for publicly insured children through Medicaid and the Children's Health Insurance Program (CHIP) and for privately insured children through the Patient Protection and Affordable Care Act (ACA), whereas Medicaid, Medicare, and the ACA do not mandate adult dental coverage. State Medicaid programs have the *option* of providing adult dental coverage, less than half have done so; 28 states have not instituted adult dental coverage. However, all states (and territories) have always provided immediate coverage for dental treatment for eligible children.

Federally Required Adult Dental Services (FRADS) including emergency procedures to address dental trauma and the management of pain and infection related to dental disease are mandated; however, all other dental benefits for adults are optional (California Medi-Cal Dental Program, 2009).

Although national rates of dental insurance remain lower than those of medical insurance, more than 26 million Americans have some form of dental coverage, with half receiving that coverage through their employer (National Association of Dental Plans, 2019), and nearly 42 million children nationally, covered by Medicaid (and thus with dental coverage) (Medicaid, 2022).

Dental Insurance in California

Most dental benefit plans are “fully insured” and regulated at the state level by the DMHC or the CDI. Fully insured plans must comply with all California’s rules and regulations; however, some employers offer self-insured plans. These plans are regulated at the federal level in accordance with the Employee Retirement Income Security Act of 1974, known as ERISA, and are exempt from state level rules and regulations. An estimated 40% of Californians are enrolled in “self-insured” dental benefit plans (CDA, 2023). The differences between California-regulated and federally regulated plans can be extensive.

A dental insurance plan may sell different products that can vary by network type (for example, a dental health maintenance organization [DHMO] or dental preferred provider organization [DPPO]). These plans may offer varied benefit designs, and serve various market segments (individual, small group, or large group). As described later in this report, DPPO plans are the most common dental plan-type, with fee-for-service reimbursement typical of the plan design. Most DPPO plans include annual benefit maximums, or caps, thus limiting total reimbursements from the dental plan. Although DHMO plans are less likely to include caps, DHMO plans require treatment authorization from the primary dentist, whereas DPPO enrollees usually are not subject to similar authorization requirements.

Dental Care in California State Programs

Medi-Cal

Since the passage of Medicaid (signed in 1965), Medi-Cal beneficiaries of any age were eligible for basic diagnostic, preventive, restorative and emergency dental procedures provided by participating dentists through the fee-for-service Medicaid dental program, Denti-Cal (with the exception of temporary cuts to the program from 2009, and fully restored in 2018).

Covered California

In Covered California plans, California residents (adults) may select a health plan with or without dental benefits. If enrollees select a health plan without dental benefits, they can still get a separate dental plan (that would be subject to AB 1048). All Covered California health insurance plans offer embedded pediatric dental coverage at no additional cost (the dental benefits are imbedded in the health plan premiums). For adults, a dental plan can be added to health plan purchases.

Medical Loss Ratio

Although not directly applicable to AB 1048, a number of states in addition to California have considered the issue of Medical Loss Ratio (MLR), which measures the share of a health care premium dollar spent on medical benefits, as opposed to company expenses such as overhead or profits. This relates to the transparency requirements included in AB 1048, intended to ensure that premium rates are justified and largely spent on dental medical claims.

MLR measures the share of a health care premium dollar spent on medical benefits, as opposed to company expenses such as overhead or profits (Kirchhoff and Mulvey, 2014). Under the Affordable Care Act, Congress established the MLR in an effort to provide “greater transparency and accountability around the expenditures made by health insurers and to help bring down the cost of health care” (Kirchhoff and Mulvey, 2014). Though the ACA established minimum MLRs for health plans, states continue to debate the issue for dental plans (Finocchio and Connolly, 2018). The MLRs required of health plans are feasible in large part because the ACA standardized benefit design by requiring 10 essential health benefits. There is a multiplicity of dental benefit designs across products and available in markets of all sizes, making standardized MLRs a more challenging policy goal for dental plans (Finocchio and Connolly, 2018).

In 2013, the California Legislature considered requiring health insurers that offered pediatric dental coverage through the Covered California Marketplace to maintain a medical loss ratio of 75%. In 2014, California passed a law requiring dental insurance plans to file annual MLR reports (Finocchio and Connolly, 2018). The legislature stopped short of requiring plans to achieve specific MLRs, deciding instead to assess reported MLRs and revisit the threshold requirement in 2018. In 2018, SB 1008 proposed a minimum MLR of 70% for dental plans in the individual and small-group markets, and 75% in the large-group market, but amendments removed these thresholds in May 2018.

Other States

Several states have been considering bills related to MLR, Massachusetts, Colorado, Arizona, Maine, and Rhode Island among them. Maine recently enacted legislation eliminating waiting periods for children under age 19. Louisiana recently passed a bill that would prohibit denial of claims based upon pre-existing conditions; but would authorize a 12-month waiting period for pre-existing conditions.

An unsuccessful 2015 bill in Massachusetts would have imposed an initial 90% MLR, increasing to 95%, on dental products. A law was passed in 2020 to eliminate wait periods for children (under age 19 years) in Maine. Via public ballot, Massachusetts residents passed a new measure, signed into law in early December of 2022, that requires the state’s insurance carriers to spend at least 83% of premium dollars on patient care.

Table 1. AB 1048. Recent Dental Insurance-Related Legislation in Other States

State	Bill Information	Status	Text Description
Arizona	SB 1302	Introduced 2023-01-30	Among other requirements, the bill would require a dental service corporation to file a medical loss ratio report that is organized by market and product type.
Oklahoma	HB 1694	Engrossed 2023-03-20	Defines how a medical loss ratio is calculated, requires medical loss ratio annual reporting; requires certain health care service plans to provide annual rebates, among other requirements.
Colorado	SB 179	Introduced 2023-03-23	The bill requires a health insurance carrier that issues, sells, renews, or offers a dental coverage plan to file, beginning in 2024, dental loss ratio forms with the division of insurance (division) for the preceding calendar year in which dental coverage was provided.
Montana	SB 415	Introduced 2023-03-13	The bill would enact the Montana dental insurance transparency and accountability act; providing definitions; providing for transparency of dental insurance premiums; providing for insurance rebates to consumers in the event of excess revenue.
West Virginia	SB 290	Engrossed 2023-02-14	This bill relates to dental health care service plans ; providing for transparency of expenditures of patient premiums; requires carriers to file annual reports ; requiring annual rebates in the form of premium reductions if funds spent for patient care is less than a certain percentage of premium funds; and providing for legislative and emergency rulemaking.
Rhode Island	H5497	Introduced 2023-03-08	Requires carriers offering dental benefit plans to annually submit information which includes the current and projected medical loss ratio for claims for their plans. The medical loss ratio would be 85%.
New Hampshire	SB 95	Introduced 2023-03-23	This bill expands New Hampshire's laws regarding requirements for the submission and filing of individual health insurance rates to include dental benefits.
Maine	SB 1266	Passed 2022-03-29	An act to require dental plan medical loss ratio reporting and review.
Maine	SB 1975	Passed 2020-03-10	Dental benefit waiting period. Eliminates any waiting periods for any dental or oral health service or treatment, except for orthodontic treatment, for an enrollee if the enrollee is under 19 years of age.
Louisiana	HB 311	Passed 2020-06-11	Among other requirements, prohibits denial of claims based upon pre-existing conditions but authorizes a 12-month waiting period for pre-existing conditions.

Source: California Health Benefits Review Program, 2023.

BACKGROUND ON ORAL HEALTH AND DENTAL INSURANCE

This section provides background on oral health, oral health disparities and barriers, dental financing, and dental insurance.

Oral Health

As explained in the US Surgeon General's sentinel 2000 report, *Oral Health in America*, and its 2021 follow up, *Oral Health in America: Advances and Challenges*, "oral health means more than healthy teeth and the absence of disease. It involves the ability of individuals to carry out essential functions such as eating and speaking as well as to contribute fully to society" (DHHS, 2000, 2021). Beyond tooth health, oral health encompasses systemic issues to include chronic oral-facial pain, mouth and throat cancers, soft tissue lesions, congenital defects of cleft lip and palate. Oral health also encompasses the connective tissues, ligaments, and bones in or interfacing with the mouth and teeth as well as the nervous, immune, and vascular systems that affect the mouth (DHHS, 2021). Various oral conditions such as infections, immune disorders, injuries, and cancers can affect functioning in other parts of the human body. Likewise, systemic conditions such as diabetes, high blood pressure, respiratory problems, and stroke can impact oral health (DHHS, 2000). A "silent epidemic" of dental and oral diseases disproportionately affects some populations of Americans, particularly children, elderly, and racial/ethnic minorities (DHHS, 2021).

The consequences of poor oral health have a negative influence on adult and pediatric speech, growth, function, and social development. Missing teeth, pain, and infection from oral diseases can limit food choices and worsen nutrition (Touger-Decker and Mobley, 2007). Many dental problems, which include dental caries and tooth loss for reasons other than injury, can be detected early and are preventable with regular care. However, access to routine oral care is not consistent in the United States, and gaps in coverage exists in California as well. Individuals without access to consistent oral health care may experience dental caries, periodontal disease, tooth loss and other treatable oral health conditions (DHHS, 2021).

Dental care is a relatively modern phenomenon, with oral health care historically limited to rudimentary tooth repair or extraction (Ring et al., 2018). As dentistry became an established profession, dental care shifted from tooth extractions and alleviating pain to hygiene and prevention of disease (Ring et al., 2018). Fluoridation of municipal water supplies in the United States became more widespread, with most communities adding supplemental fluoride by the 1940s and 1950s. The vast majority of dentists in the United States work in private practice settings, whereas smaller numbers of dentists work in hospitals, public health clinics, military settings, or government facilities such as prisons (Ring et al., 2018).

Tooth Decay

Dental caries, cavities, or tooth decay, is a common chronic infectious disease resulting from tooth-adherent cariogenic bacteria which metabolize sugars to produce acid, demineralizing the tooth structure over time. Dental caries is a major healthcare problem and is the most common noncommunicable disease, affecting 97% of the worldwide population during their lifetimes (ADA, 2021a; Selwitz et al., 2007; World Health Organization, 2017). There are five stages of tooth decay: white spot lesion, enamel decay, dentin decay, pulp involvement, and tooth loss. Of note, the early stages of tooth decay may be reversible, while later stages including pulp involvement and tooth loss can require root canal treatment or even surgical extraction. Tooth loss and pulp involvement may also lead to abscesses or potentially life-threatening systemic sepsis infection.

Periodontal Disease

Periodontal diseases are mainly the result of infections and inflammation of the gums and bone that surround and support the teeth. A 2012 CDC report found that 47.2% of adults in the United States aged 30 years and older have some form of periodontal disease. Periodontal disease also increases with age, with 70.1% of adults 65 years and older have periodontal disease (Eke et al., 2012).

The different types of periodontal disease are often classified by the three stages of the disease, including: gingivitis, mild periodontitis, and moderate to advanced periodontitis. While gingivitis can be resolved with home care and dental prophylaxis, progressive periodontitis may lead to bone loss, gum damage and eventual need for surgical tooth extraction (CDC, 2013; Johns Hopkins Medicine, 2023).

Oral Health Disparities and Barriers

Costs are a major reason that children and their parents delay or forgo oral health care (Wisk and Witt, 2012). Oral health care presents the highest level of financial barrier compared with all other types of health care services, particularly for adults (Vujicic et al., 2016), even if total expenditures are less in dental care.

Oral health is an essential component of overall health, yet low-income populations experience significant barriers to dental care compared with high-income individuals. In fact, compared with medical care services, prescription drug services, mental health care, and eyeglass services, more people reported not getting needed dental services due to cost, irrespective of age and income (Vujicic et al., 2016). As explained later in this *Background* section, this lack of dental care may be a result of dental insurance commonly including restrictions (such as waiting periods, pre-existing exclusions, and annual benefit maximums) that do not apply to medical insurance. Various dental resources exist for the lower-income population, such as Medicaid dental coverage in some states including California, dental clinics within federally qualified health centers (FQHCs), school-based health and dental centers, academic teaching dental clinics, and governmental public health dental hygienists (Northridge et al., 2020). In California, approximately 20% of communities experience shortages of dentists; most of these communities are rural even though the majority of California's population resides in urban or suburban communities (Mertz and Grumbach, 2001). More recent studies also indicate that rural populations have reduced access to dentists and oral health services (Northridge et al., 2020; Patrick et al., 2006; Pourat et al., 2021).

Education and income are also strongly associated with oral health measures. College graduates have over 80% increased odds of reporting a dental examination in the prior year compared to Americans without a high school diploma, whereas high school graduates have over 40% increased odds as compared to those without a high school diploma (Okunseri et al., 2015). Regardless of one's own educational attainment, having parents with college or post-college education was also significantly associated with likelihood of dental examinations. Increasing levels of income were also strongly associated with both increased dental visits and improved oral health measures such as caries prevalence (Northridge et al., 2020; Okunseri et al., 2015). In California, lower-income adults were less likely to have timely dental visits and more likely to visit for dental problems (as opposed to preventive care) as compared to higher-income Californians (Pourat and Ditter, 2020).

Racial disparities in dental care access have narrowed over the last decade for children, but Black and Hispanic children are still less likely to visit a dentist than White children (ADA, 2021b). Multiple barriers to care remain, such as transportation, access to caregiving, and fear of dental treatment (Northridge et al., 2020). Financial barriers to dental care can also exacerbate other social issues, as explained in a California study that reported that unaffordable dental care is associated with frequent school absences in children (Pourat and Nicholson, 2009).

Dental Spending

Oral health care services are generally provided and financed through a two-tier system in the United States. Approximately two-thirds of the American population utilizes commercial dental insurance or out-of-pocket spending while the remaining one-third use Medicaid and various government or discounted safety-net clinics (Northridge et al., 2020). However, this two-tier system of commercial and private spending or government-financed programs still does not adequately support lower-income populations, particularly in rural areas. In terms of reimbursement rates, numerous studies illustrate a statistically significant positive relationship between Medicaid reimbursement rates and dental care utilization among publicly insured children as well as dentist participation in Medicaid (Buchmueller et al., 2013).

Dental spending represents approximately 4% of total health care spending in California in 2020 (although CHBRP notes that 2020 have been atypical given utilization delays of dental services during the pandemic). This is a reduction from the past (6% in 2010 and 5% in 2015) as dental spending growth was significantly slower than the growth of other components of health care spending (CHCF, 2023). California's dental spending is similar to national averages. Unlike most other health spending, government programs (e.g., Medicare, Medicaid, Veterans Health Administration) account for a small proportion of dental spending, with dental expenditures roughly split between private insurance and out-of-pocket spending (Versaci, 2022). The many federal and state health insurance mandates and protections largely do not apply to dental care.

While Americans with dental insurance are more likely to access dental care, commercial dental benefits and spending limits have not increased with inflation (Northridge et al., 2020). As a result, out-of-pocket spending has become more common, and dental care, particularly for costlier services, may be less accessible given the fixed dollar benefits. Unlike medical insurance, dental insurance commonly includes an annual benefit maximum, or cap, thus limiting many enrollees to a fixed amount of covered dental services (ADA, 2022; Northridge et al., 2020). These caps, which typically range for \$1,500 to \$2,500 annually, often apply to both commercial or private dental insurance and government-sponsored or public insurance. As a result of these caps, significant out-of-pocket spending may be required for more expensive dental services even when these services are covered by the dental insurance plan. Although preventive dental care may require more subsequent oral health care services, the provision of preventive dental care is associated with reduced total dental expenditures (Pourat et al., 2018).

Dental Insurance

Fee for service financing was the first mode of payment for oral health services and remained the main type of payment for many years until the other forms of payment came into existence (Burt and Eklund, 1992). The mid to late 1940s saw the launch of the first prepaid or broader based insurance plans. These fee for service or prepaid plans, referred to as indemnity insurance, generally reimbursed consumers for dental care at a fixed level for each defined dental service. Eventually preferred provider organization (PPO) dental insurance was introduced in the 1960s, where insurers directly paid the dentists and consumers were limited to dentists who contracted with the insurance plan. While PPO dental insurance is now the most prevalent, health maintenance organization (HMO) insurance plans were introduced in the 1970s. These dental HMOs generally have less cost sharing as compared to PPO plans, but enrollees are required to receive all services from a single dentist or dental practice.

Classes of Dental Services and Common Treatments

Most dental insurance plans cover various dental services at different reimbursement or coverage levels. Dental insurance commonly divides services into preventive and diagnostic, basic restorative services, major restorative services, and orthodontics (ADA, 2022). Insurance coverage of preventive and diagnostic services are typically the most generous. As many dental conditions may be preventable with appropriate dental hygiene practices and early screening; there is generally zero or minimal cost sharing

for these services. Whereas preventive and diagnostic services identify problems early on, basic restorative services include the treatments for common dental problems. These basic services are generally nonsurgical in nature, such as simple extractions and basic root canals. Major restorative services, however, are often complex or lengthy, typically requiring more time and expense than basic services. These major services include dental crowns, dentures, and surgical tooth extractions. Orthodontic services are sometimes included under major restorative services, but orthodontic coverage varies significantly by plan. Orthodontics can include braces, aligners, and retainers. More detailed explanations of key dental conditions and treatments can be found in the *Medical Effectiveness* section of this report.

Table 2. Classes of Dental Services and Typical Plan Designs

	Class I (or A)	Class II (or B)	Class III (or C)	Class IV (Centers for Disease Control and Prevention)
Description	Preventive and diagnostic services	Basic restorative services	Major restorative services	Orthodontics
Common services	Dental exams Cleanings and prophylaxis X-rays Fluoride treatments	Fillings and composites Periodontics (gum treatments) Endodontics (root canals) Simple/routine tooth extraction	Crowns, inlays, casts Prosthodontics (bridges, dentures, implants) Surgical tooth extraction	Braces, aligners, retainers
Typical coverage	100%	80%	50%	50%*
Enrollees responsible for cost-sharing	Minimal or none	Common	Common	Common

Source: American Dental Association, 2022.

Note: *If orthodontics are covered by a dental plan, orthodontics are typically subject to an annual and maximum spending limit and may only be covered for children under age 18 years.

Pre-existing Conditions and Waiting Periods

Some plans include pre-existing condition exclusions and waiting periods as part of the dental plan design. Waiting periods can be variable and may depend on the specific dental service, but these waiting periods are commonly 3 or 6 months. Whereas the Affordable Care Act and additional California regulations largely banned pre-existing condition exclusions and treatment waiting periods while mandating that all individuals obtain medical insurance, these regulations do not apply to the dental insurance market. The dental insurance market is largely unregulated when it comes to pre-existing condition exclusions and waiting periods. Some dental insurers include these restrictions to try to address adverse selection, in which sicker individuals or individuals who have postponed needed dental treatments are more likely to purchase insurance than healthier individuals with fewer treatment needs (Calcoen and van de Ven, 2018). Although pre-existing condition exclusions and waiting periods differ by plan, these conditions are typically applied to costlier dental services. These may include exclusions for missing teeth, given the costly nature of implants and dentures. If dentures and implants are covered, they may be subject to a waiting period of several months before otherwise covered treatments are allowed. Of note, some dental plans with these exclusions may waive the exclusions if enrollees can

demonstrate proof of continuous dental insurance with a different dental plan immediately prior to the current dental plan (ADA, 2022).

MEDICAL EFFECTIVENESS

As discussed in the *Policy Context* section, AB 1048 would prohibit a health care service plan or health insurer that covers dental services from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or pre-existing condition provision upon an enrollee or insured on or after January 1, 2024. The medical effectiveness review summarizes findings from evidence on the impact of dental waiting periods, pre-existing condition provisions, delayed dental procedures, delayed dental disease treatment, and untreated dental disease on health outcomes.

Research Approach and Methods

In addition to conducting a review of literature on the impact of dental waiting period provisions and pre-existing condition provisions, CHBRP reviewed literature on the impact of delayed dental care and untreated dental issues because dental waiting period or pre-existing condition provisions may cause delays to treatments of oral health conditions.

The dental procedures of interest to the *Medical Effectiveness* analysis of AB 1048 include basic restorative (Class II) and major restorative (Class III) dental services (see the *Background* section), as these are the categories of procedures that are included in dental insurance waiting periods. Basic restorative dental services include fillings, simple (nonimpacted) extractions, root planing, periodontal scaling, and root canals. Major restorative dental services include complex dental work and surgical procedures, such as crowns, bridges, implants, extraction of impacted teeth, complex oral surgery, and denture work (Anthem Insurance Companies; HealthPartners; Humana, 2022). CHBRP did not analyze the impact of delayed preventative dental services (e.g., examinations and cleaning, x-rays, fluoride treatments, tooth sealing) because most dental insurance plans do not require a waiting period for preventative dental services.

The search was limited to abstracts of studies published in English. The search was limited to studies published from 1980 to present. Of the 569 articles found in the literature review, 52 were reviewed for potential inclusion in this report on AB 1048, and a total of 9 studies were included in the medical effectiveness review for this report. The other articles were eliminated because they did not focus on the harms of the waiting period and pre-existing condition provisions, harms of delayed and untreated dental issues, were not conducted in the United States, were of poor quality, or did not report findings from clinical research studies. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.³ Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. What is the impact of dental waiting period provisions on oral health and general health outcomes?
2. What is the impact of pre-existing condition restrictions on health outcomes?

³³ Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. For more information on CHBRP's use of grey literature, visit <https://www.chbrp.org/about/analysis-methodology/medical-effectiveness-analysis>.

3. What is the impact of delayed dental procedures (e.g., fillings, nonsurgical extractions, crowns, bridges, dentures) on health outcomes?
4. What is the impact of delayed treatment of dental disease (e.g., caries, periodontal disease) on health outcomes?
5. What is the impact of untreated dental disease (e.g., caries, periodontal disease) on health outcomes?

Methodological Considerations

CHBRP did not identify any studies that examined the impact of dental waiting periods and pre-existing condition provisions in dental insurance plans (Key Questions #1 and #2) or any studies that examined the impact of delayed dental procedures (Key Question #3). With regard to harms of delayed treatment of dental diseases (Key Question #4), CHBRP did not identify any studies that examined the impact of delayed treatment of caries, and identified a limited number of studies of periodontal disease. CHBRP identified some studies which assessed outcomes of untreated caries in children and untreated periodontal disease in adults (Key Question #5).

Due to the lack of literature on waiting periods and pre-existing conditions, CHBRP searched for studies that assessed the impact of delayed dental procedures, the impact of delayed treatment of common dental diseases, and the impact of untreated dental disease. The generalizability of these studies to AB 1048 are limited because the duration in which dental disease was left untreated in these studies may not be comparable to the duration of a dental waiting period. In addition, some studies were conducted in populations of pregnant people and measured birth outcomes, which has limited generalizability to a broader population.

Outcomes Assessed

Studies of untreated dental disease have examined a range of health outcomes. These include dental pain or toothache, measures of severity of particular dental diseases, systemic or chronic condition health care costs, and hospitalizations. Oral health-related quality of life measures were also examined. These measures generally include dental pain, dissatisfaction with the appearance of one's teeth, and difficulty or dysfunction in drinking and eating, rest and sleep, home tasks, social interaction, speech and communication, work, school and leisure.

Study Findings

CHBRP identified nine studies that examined the impact of delayed treatment of dental disease and impact of untreated dental disease, including caries and periodontal disease. CHBRP did not identify any studies that examined the impact of dental waiting periods, pre-existing condition provisions, or delayed dental procedures.

Each subsection is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms is included in the box below, and more information is included in Appendix B.

The following terms are used to characterize the body of evidence regarding an outcome:

Clear and convincing evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

Preponderance of evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

Inconclusive evidence indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

More information is available in Appendix B.

Impact of Dental Waiting Period Provisions on Health Outcomes

CHBRP did not identify any studies that examined the impact of dental waiting period provisions in dental insurance plans on health outcomes.

Summary of findings regarding impact of dental waiting period provisions on health outcomes:

There is insufficient evidence to determine whether the elimination of dental waiting period provisions impacts health outcomes because CHBRP did not identify any studies on this topic. The absence of evidence is not evidence of no effect. Dental waiting periods may cause some people to delay obtaining dental procedures or treatment of dental disease which could affect their health.

Figure 1. Impact of Dental Waiting Period Provisions on Health Outcomes

NOT EFFECTIVE		INSUFFICIENT EVIDENCE			EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing

Impact of Pre-Existing Condition Provisions on Health Outcomes

CHBRP did not identify any studies that examined the impact of pre-existing condition provisions in dental insurance plans on health outcomes.

Summary of findings regarding the impact of pre-existing condition restrictions on health outcomes:

There is insufficient evidence to determine whether the elimination of pre-existing condition provisions impacts health outcomes because CHBRP did not identify any studies on this topic. The absence of evidence is not evidence of no effect. Pre-existing condition restrictions may cause some people to delay obtaining dental procedures or treatment of dental disease until they have sufficient funds to pay out of pocket, which could affect their health.

Figure 2. Impact of Pre-existing Condition Provisions on Health Outcomes

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Impact of Delayed Dental Procedures on Health Outcomes

CHBRP did not identify any studies that examined the impact of delayed basic and major dental procedures on health outcomes.

Summary of findings regarding the impact of delayed dental procedures on health outcomes: There is insufficient evidence to determine whether a delay in receiving basic or major dental procedures impact health outcomes because CHBRP did not identify any studies on this topic. The absence of evidence is not evidence of no effect.

Figure 3. Impact of Delayed Dental Procedures on Health Outcomes

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Impact of Delayed Treatment of Dental Diseases on Health Outcomes

Caries

CHBRP did not identify any studies that examined the impact of delayed treatment of caries on health outcomes.

Summary of findings regarding the impact of delayed caries treatment on health outcomes: There is insufficient evidence to determine whether a delay in caries treatment impacts health outcomes because CHBRP did not identify any studies on this topic. The absence of evidence is not evidence of no effect. As discussed in the *Background* section, if a cavity is not treated, the decay may reach the pulp, which can lead to an abscess. If a cavity goes beyond the pulp, it may lead to severe infection and tooth loss.

Figure 4. Impact of Delayed Caries Treatment on Health Outcomes

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Periodontal disease

CHBRP identified two RCTs that compared the impact of delayed and nondelayed treatment on health outcomes for pregnant people with periodontal disease. In Offenbacher et al. (2009), 1,806 pregnant people were randomized to receive four supragingival and subgingival scaling and root planing procedures either before 23 weeks of gestation or after delivery. At baseline, there were no differences

between the nondelayed treatment and delayed control arms for any of the periodontal or obstetric measures. While the rate of preterm delivery was lower for the nondelayed treatment group compared to the delayed control group (11.5% vs. 13.1%), the findings were not significant.

Michalowicz et al. (2006) conducted a similar study of 823 pregnant people randomized to undergo scaling and root planing either before 21 weeks gestation or after delivery. There was no significant difference in birth weight (3,239 g vs. 3,258 g), the rate of delivery of infants that were small for gestational age (12.7% vs. 12.3%), or risk of preterm delivery (12.0% vs. 12.8%) between the nondelayed treatment group and delayed treatment control group.

Summary of findings regarding the impact of delayed periodontal disease treatment on health outcomes: Two studies found no significant effect of delayed periodontal disease treatment on the rate of preterm delivery of pregnant people. However, there is insufficient evidence to determine whether a delay in periodontal disease treatment impacts health outcomes because the studies' findings are not generalizable to nonpregnant people and because the studies only addressed birth outcomes and did not examine a broader range of health outcomes that could be affected by delayed treatment of periodontal disease.

Figure 5. Impact of Delayed Periodontal Disease Treatment on Health Outcomes



Impact of Untreated Dental Diseases on Health Outcomes

Caries

CHBRP identified two articles that accessed the impact of untreated caries on health outcomes. Both studies were conducted in the early 2000s on children in Maryland.

The most common immediate consequence of untreated dental caries is dental pain, or toothache. Dental pain can interfere with a child's regular activities, such as eating, sleeping, playing, attending school, as well as oral hygiene (Edelstein, 2006; Pau et al., 2007). Analyzing data from the 2000-2001 Survey of Oral Health Status of Maryland School Children, Vargas et al. (2005) found 28.2% of all school age children in kindergarten and third grade who had untreated caries experienced dental pain, compared to 11.8% of all school age children in kindergarten and third grade. Another study of Maryland Head Start preschool children found that 17% of children with caries experience had complained of a toothache and 9% reportedly cried because of the toothache, compared to 10% and 5% of all children who complained of a toothache or cried of pain regardless of whether they had caries (Vargas et al., 2002).

Summary of findings regarding the impact of untreated caries health outcomes: There is limited evidence from two studies that untreated caries is associated with greater rates of dental pain in children. No studies on the impact of untreated caries on the health outcomes of adults were identified by CHBRP.

Figure 6. Impact of Untreated Caries on Health Outcomes of Children

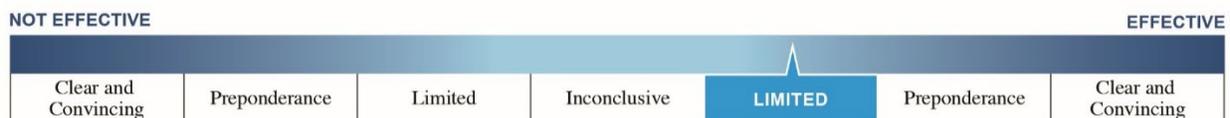


Figure 7. Impact of Untreated Caries on Health Outcomes of Adults



Periodontal disease

CHBRP identified five articles that assessed the impact of untreated periodontal disease on health outcomes. Three of the five articles studies investigated the natural history of untreated moderate to severe periodontal disease by observing a group of adult patients over a period of time (Buckley and Crowley, 1984; Harris, 2003; Reddy et al., 2000). All three studies found that the group of patients with untreated periodontal disease had greater breakdown and tooth loss than one would expect to see in a group of patients if their periodontal disease was treated.

One retrospective observational study assessed the impact of untreated periodontal disease on systemic health medical costs and number of hospitalizations. Examining insurance claims data from 338,891 individuals, Jeffcoat et al. (2014) found that among people with type 2 diabetes, coronary artery disease, cerebral vascular disease, rheumatoid arthritis, and pregnancy, people who received optimal treatment for periodontal disease (defined as four or more visits over the course of one year) incurred significantly lower costs and fewer hospitalization than people whose periodontal disease was not treated.

CHBRP also identified one study that assessed the impact of periodontal disease on oral health-related quality of life measures (Reisine et al., 1989). Compared with a sample of patients without symptoms of dental disease, patients with periodontal had significantly higher rates of mild and moderate pain, experiences of pain in the past week, discomfort in chewing, and discomfort in the appearance of their teeth. A larger proportion of periodontal disease patients also rated their oral health status as “poor.” Periodontal patients experienced significantly higher rates of dysfunction in rest and sleep, home tasks, social interaction, intellectual activities, speech and communication, work, and leisure.

Summary of findings regarding the impact of untreated periodontal disease on health outcomes:

There is a preponderance of evidence from five studies that untreated periodontal disease is associated with greater rates of probing depth, attachment loss, tooth loss, health care costs, hospitalizations, experiences of dental pain, discomfort, and dysfunction in regular activities in adults. CHBRP did not identify any studies that assessed the impact of untreated periodontal disease in children.

Figure 8. Impact of Untreated Periodontal Disease on Health Outcomes of Adults



Summary of Findings

The medical effectiveness review examined 9 articles of literature. None of the literature assessed the impact of dental waiting periods, pre-existing condition provisions, or delayed dental procedures. All nine articles assessed the impact of delayed dental disease treatment and untreated dental disease on health outcomes. The medical effectiveness review reached the following conclusions:

- There is insufficient evidence to determine whether the elimination of dental waiting period provisions impacts health outcomes because CHBRP did not identify any studies on this topic.

- There is insufficient evidence to determine whether the elimination of pre-existing condition provisions impacts health outcomes because CHBRP did not identify any studies on this topic.
- There is insufficient evidence to determine whether a delay in receiving basic or major dental procedures impact health outcomes because CHBRP did not identify any studies on this topic.
- There is insufficient evidence to determine whether a delay in caries treatment impacts health outcomes because CHBRP did not identify any studies on this topic.
- There is insufficient evidence to determine whether a delay in periodontal disease treatment impacts health outcomes because the studies identified are not generalizable to non-pregnant people and only assessed the impact of delaying treatment on birth outcomes.
- There is limited evidence that untreated caries is associated with greater rates of dental pain in children.
- There is a preponderance of evidence that untreated periodontal disease is associated with greater rates of probing depth, attachment loss, tooth loss, health care costs, hospitalizations, experiences of dental pain, discomfort, and dysfunction in regular activities in adults.

Table 3. Impacts of AB 1048 on Benefit Coverage, Utilization, and Cost, 2024

	Baseline (2024)	Postmandate Year 1 (2024)	Increase/ Decrease	Percentage Change
Benefit coverage (dental)				
Total enrollees with dental insurance subject to AB 1048 (a)	10,948,000	10,948,000	0	0.00%
Percentage baseline enrollees with no waiting periods or pre-existing condition provisions	43%	100%	57%	134.41%
Number of enrollees with fully compliant coverage with AB 1048	4,671,000	10,948,000	6,277,000	134.38%
Cost				
Covered benefits per member per month (PMPM)	\$28.85	\$29.31	\$0.46	1.59%
Expenditures (dental)				
<i>Premiums</i>				
Employer-sponsored (b)	\$257,625,000	\$261,127,000	\$3,502,000	1.36%
<i>Enrollee premiums (expenditures)</i>				
Enrollees, individually purchased insurance	\$44,676,000	\$46,681,000	\$2,005,000	4.49%
Outside Covered California	\$36,111,000	\$37,827,000	\$1,716,000	4.75%
Through Covered California	\$8,565,000	\$8,854,494	\$289,000	3.37%
Enrollees, group insurance (c)	\$110,411,000	\$111,912,000	\$1,501,000	1.36%
<i>Enrollee out-of-pocket expenses</i>				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	\$78,951,000	\$80,205,000	\$1,254,000	1.59%
Total expenditures	\$491,663,000	\$499,925,000	\$8,262,000	1.68%

Source: California Health Benefits Review Program, 2023.

Notes: (a) Enrollees in commercial plans and policies regulated by DMHC or CDI. Includes those associated with Covered California and CalPERS.

(b) In some cases, a union or other organization. Excludes CalPERS.

(c) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.

Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 1048 would prohibit health plans and health policies regulated by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or pre-existing condition provision.

AB 1048 applies to commercial individual and group dental plan enrollees. As noted in the *Policy Context* section, AB 1048 would not impact self-insured employer plans, CalPERS enrollees' or apply to Medi-Cal beneficiaries' benefit coverage.

This section reports the potential incremental impacts of AB 1048 on estimated baseline benefit coverage, utilization, and overall cost.

Analytic Approach and Key Assumptions

As mentioned above, AB 1048 will prohibit the use of waiting periods and pre-existing condition clauses for health plans that provide dental services. To estimate the impact of this bill, CHBRP considered the following three provisions that are likely to have the most impact on premium:

- 1) **Waiting periods.** This contract provision limits coverage for a specified period of time following the insured's effective date of coverage. Plans and policies differ about the length of time, commonly 3 to 12 months, and types of waiting periods that may apply. For example, preventative and diagnostic care may be available with a waiting period applying to basic restorative care such as fillings, extractions, or root canals. Other plans may only impose a waiting period on major restorative care such as crowns and dentures. The waiting periods applied may vary by the type of service.
- 2) **Missing teeth clauses.** These provisions vary but limit an enrollee's ability to receive specific services for teeth that were extracted prior to enrollment in the policy.
- 3) **Denture clauses.** Some policies may limit the enrollee's ability to receive dentures if the enrollee received dentures under a different plan or policy within a specified time frame.

AB 1048 would also require the Department of Managed Health Care and the Department of Insurance to establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a specialized health care service plan contract or specialized health insurance policy covering dental services is unreasonable, or not justified, under the applicable requirements of the rate review provisions under existing law. CHBRP did not estimate the impact of imposing rate reviews on these policies.

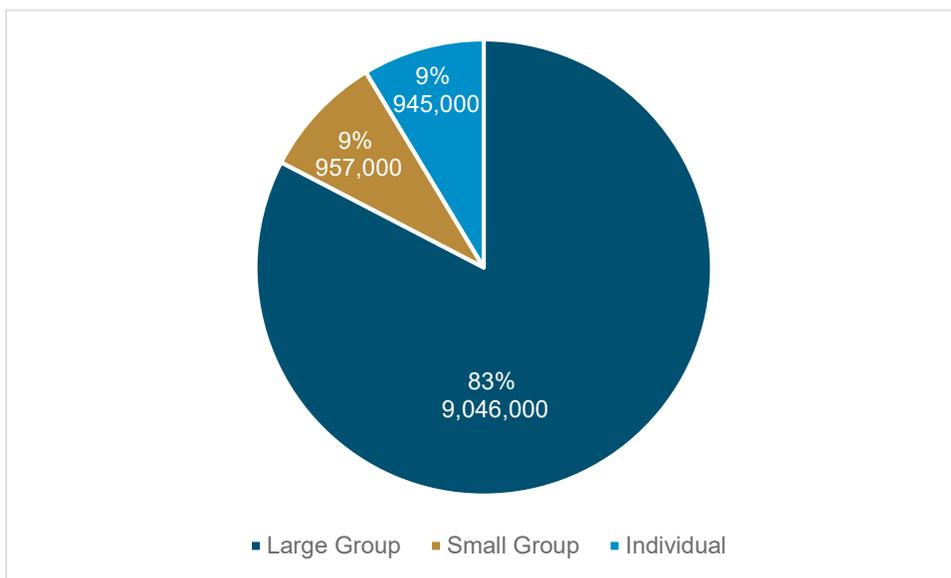
At baseline, enrollees may experience delayed or untreated dental conditions due to waiting periods and pre-existing condition provisions. CHBRP did not measure the impact of savings resulting from timelier care.

For further details on the underlying data sources and methods used in this analysis, please see Appendix C.

Baseline and Postmandate Benefit Coverage

The California population enrolled in a commercial fully insured dental plan by line of business is displayed in Figure 9 (Source: 2022 NADP Dental Benefits Report. Represents 2021 population). Over 80% of enrollees in the commercial market have a large-group dental plan.

Figure 9. California Population with Dental Insurance by Line of Business

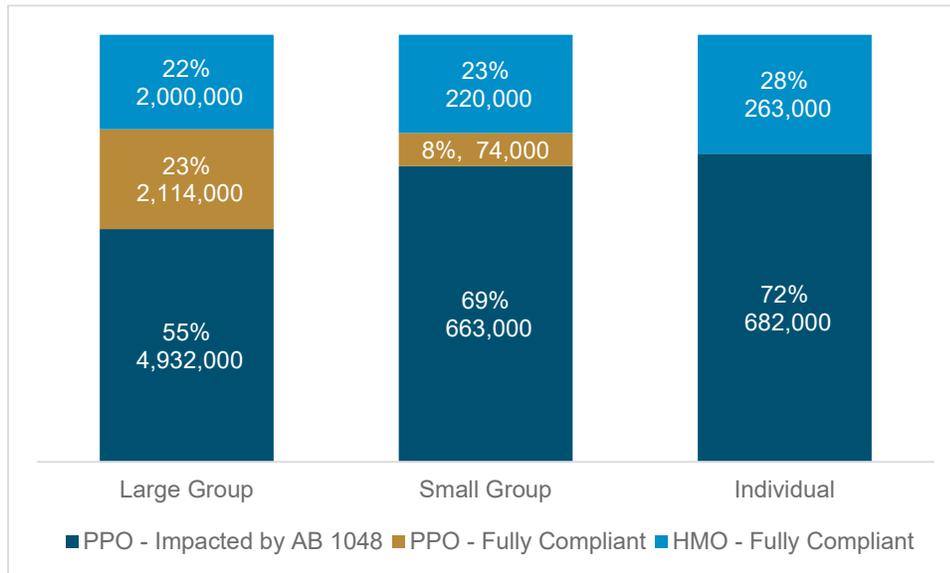


CHBRP does not have access to a dataset containing current benefit coverage statistics for each line of business. Benefit coverage assumptions were determined by professionals in the healthcare industry who specialize in pricing dental benefits. At baseline, CHBRP assumed 43% of enrollees with dental insurance that would be subject to AB 1048 do not have waiting periods or pre-existing condition clauses. CHBRP assumed 100% of enrollees with dental health maintenance organization (HMO) coverage and 26% of enrollees with dental preferred provide organization (PPO) coverage have fully compliant coverage at baseline.

At baseline, CHBRP assumed 100% of enrollees with dental PPO individual policies have at least one of the provisions outlined above. CHBRP assumed 70% of enrollees with dental PPO large-group policies have at least one of the provisions outlined above. Waiting periods and pre-existing condition clauses are more common on individual policies because there is more opportunity for adverse selection, (i.e., an enrollee purchasing a policy because they need dental services), when compared to enrollees with group policies which have an annual open enrollment period and generally provide continuous benefits year after year.

Figure 10 summarizes commercial coverage by network type (HMO vs. PPO) and compliance with AB 1048 by line of business. Of the 9,046,000 million large-group enrollees, 55%, or 4,932,000, are enrolled in a PPO plan that would be impacted by AB 1048. Small group and individual have fewer enrollees that are impacted by AB 1048 but a greater percentage of those markets, approximately 70%, are impacted by AB 1048.

Figure 10. Baseline Commercially Insured Dental Enrollees by Line of Business, Network, and Assumed Average Compliant Coverage



Postmandate, 100% of enrollees with dental insurance subject to AB 1048 would not have waiting periods or pre-existing condition clauses.

Baseline and Postmandate Utilization and Cost

AB 1048 may increase postmandate utilization of dental services for two reasons:

- 1) Elimination of waiting periods will allow enrollees to access services sooner.
- 2) Eliminating pre-existing condition exclusions will allow enrollees to access services that were previously not covered under their policy.

AB 1048 will not impact per-unit cost of services.

AB 1048 would increase the average cost of covered benefits across all commercial lines of business \$0.46 per member per month (PMPM) (1.59%), from \$28.85 PMPM at baseline to \$29.31 PMPM postmandate.

Because enrollees with dental HMO policies have compliant coverage, the cost of covered benefits for enrollees with dental HMO policies remain unchanged from baseline. The increase in the cost of covered benefits PMPM would only occur for enrollees with dental PPO policies. For PPO policies, the estimated average cost of covered benefits would increase \$0.59 PMPM (1.7%), from \$34.00 PMPM at baseline to \$34.59 PMPM postmandate.

Baseline and Postmandate Expenditures

AB 1048 would increase total net annual dental expenditures by \$8,263,692, or 1.68%, for enrollees with Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies. This is due to a \$7,009,541 increase in total dental insurance premiums paid by

employers and enrollees for newly covered benefits, and a \$1,254,150 increase in enrollee expenses for covered benefits. CHBRP was not able to estimate the cost of noncovered benefits at baseline.

Premiums

Changes in premiums as a result of AB 1048 would vary by market segment. Enrollees with dental HMO plans will not see a change in premiums as a result of AB 1048. Dental PPO premium increases range from \$0.52 (1.3%) for enrollees with large-group policies to \$2.94 (4.9%) for enrollees with individual policies. As mentioned above, individual policies have more waiting period and pre-existing condition clauses, so enrollees with these policies will experience a larger premium impact as a result of AB 1048 when compared to other lines of business.

Individual Covered California dental PPO premiums PMPM will increase \$2.50 (4.9%), from \$51.25 PMPM to \$53.75 PMPM.

Enrollee Cost-Sharing

CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of dental services and therefore an increase in enrollee cost sharing. AB 1048 does not impact benefit limits or caps on insurance payment. However, there will be increases in enrollee cost sharing as enrollees receive services that were previously excluded due to waiting periods and pre-existing condition provisions.

Changes in enrollee cost sharing as a result of AB 1048 would vary by market segment. Enrollees with dental HMO plans will not see a change in cost sharing as a result of AB 1048. Dental PPO cost-sharing increases range from \$0.11 (1.3%) for enrollees with large-group policies to \$0.43 (4.9%) for enrollees with individual policies. As mentioned above, individual policies have more waiting period and pre-existing condition clauses, so enrollees with these policies will experience a larger cost-sharing impact as a result of AB 1048 when compared to other lines of business.

Individual Covered California dental PPO cost sharing PMPM will increase \$0.36 (4.9%), from \$7.43 to \$7.79.

It is possible that some enrollees incurred expenses related to dental services for which coverage was denied due to waiting periods or pre-existing condition exclusions, but CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact.

Average enrollee out-of-pocket expenses per user

CHBRP is unable to estimate the number of enrollees and average expenses per enrollee purchasing dental services outside of their dental policy due to waiting periods and pre-existing condition clauses.

Users of dental services outside of their dental policy due to waiting periods and pre-existing condition clauses at baseline may see sizeable savings due to network discounts and cost sharing postmandate. For example, at baseline, a user may pay \$1,000 for a dental service that is not covered due to the waiting period. Postmandate, this user would be able to use their dental benefits for this service. Assuming a 25% network discount and 50% cost sharing, the \$1,000 service at baseline would cost the user \$375 postmandate. This is a savings of \$625, or 62.5%. Actual per user savings will vary by cost of services, discounts, and benefit designs.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health

care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Table 4. AB 1048 Impacts on Benefit Coverage, Utilization, and Cost by Line of Business, 2024

	Commercial Dental PPO Plans (by Market)			Commercial Dental HMO Plans (by Market)			TOTAL
	Large Group	Small Group	Individual	Large Group	Small Group	Individual	
Enrollee counts							
Total enrollees in plans/policies subject to state mandates	7,046,000	737,000	682,000	2,000,000	220,000	263,000	10,948,000
Total enrollees in plans/policies subject to AB 1048	7,046,000	737,000	682,000	2,000,000	220,000	263,000	10,948,000
Premium costs							
Baseline premium	\$40.70	\$55.85	\$59.49	\$18.26	\$16.38	\$15.60	\$37.70
Postmandate premium	\$41.21	\$57.72	\$62.43	\$18.26	\$16.38	\$15.60	\$38.34
Projected premium impact of AB 1048	\$0.52	\$1.87	\$2.94	\$0.00	\$0.00	\$0.00	\$0.64
Percent change insured premiums	1.3%	3.3%	4.9%	0.0%	0.0%	0.0%	1.7%
Enrollee cost-sharing							
Baseline cost sharing for covered benefits	\$8.51	\$8.32	\$8.63	\$2.96	\$2.07	\$2.37	\$7.21
Postmandate cost sharing for covered benefits	\$8.61	\$8.60	\$9.05	\$2.96	\$2.07	\$2.37	\$7.33
Projected cost sharing impact of AB 1048	\$0.11	\$0.28	\$0.43	\$0.00	\$0.00	\$0.00	\$0.11
Percent change enrollee cost-sharing	1.3%	3.3%	4.9%	0.0%	0.0%	0.0%	1.6%
Total expenditures							

Baseline total expenditures	\$49.20	\$64.17	\$68.12	\$21.23	\$18.45	\$17.98	\$44.91
Postmandate total expenditures	\$49.83	\$66.31	\$71.48	\$21.23	\$18.45	\$17.98	\$45.66
Projected change total expenditures	\$0.62	\$2.14	\$3.37	\$0.00	\$0.00	\$0.00	\$0.75
Percent change total expenditures	1.3%	3.3%	4.9%	0.0%	0.0%	0.0%	1.7%

Source: California Health Benefits Review Program, 2023.

Key: HMO = health maintenance organization; PPO = preferred provider organization.

Table 5. AB 1048 Impacts on Benefit Coverage, Utilization, and Cost for Individual Covered California, 2024

	Individual Covered California Plans		
	PPO	HMO	TOTAL
Enrollee counts			
Total enrollees in plans/policies subject to state mandates	116,000	217,000	333,000
Total enrollees in plans/policies subject to AB 1048	116,000	217,000	333,000
Premium costs			
Baseline premium	\$51.22	\$12.09	\$25.72
Postmandate premium	\$53.72	\$12.09	\$26.59
Projected premium impact of AB 1048	\$2.50	\$0.00	\$0.87
Percent change insured premiums	4.9%	0.0%	3.4%
Enrollee cost sharing			
Baseline cost sharing for covered benefits	\$7.43	\$1.84	\$3.78
Postmandate cost sharing for covered benefits	\$7.79	\$1.84	\$3.91
Projected cost sharing impact of AB 1048	\$0.36	\$0.00	\$0.13
Percent change enrollee cost sharing	4.9%	0.0%	3.3%
Total expenditures			
Baseline total expenditures	\$58.65	\$13.92	\$29.50
Postmandate total expenditures	\$61.51	\$13.92	\$30.50
Projected change total expenditures	\$2.86	\$0.00	\$1.00
Percent change total expenditures	4.9%	0.0%	3.4%

Source: California Health Benefits Review Program, 2023.

Key: HMO = health maintenance organization; PPO = preferred provider organization.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impact of AB 1048, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Waiting periods and pre-existing condition limitations are tools employed by dental carriers to prevent anti-selection (or adverse risk selection), from enrollees purchasing dental insurance when they need dental services. Eliminating these provisions may result in enrollees lapsing their coverage and re-signing up as dental services are needed. With fewer enrollees not requiring dental services purchasing dental insurance, the cost of dental services would be spread across a smaller pool of enrollees, resulting in higher premiums.

The bill could potentially allow some enrollees to get dental care sooner than they otherwise would have, or receive coverage for previously excluded services. This could result in some improvements in dental outcomes, although evidence is limited (due to the insufficient evidence base).

APPENDIX A TEXT OF BILL ANALYZED

On February 21, 2023, the California Assembly Committee on Health requested that CHBRP analyze AB 1048 as introduced on February 15, 2023.

ASSEMBLY BILL

NO. 1048

Introduced by Assembly Member Wicks

February 15, 2023

An act to amend Section 1385.02 of, and to add Section 1371.194 to, the Health and Safety Code, and to amend Section 10181.2 of, and to add Section 10120.41 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1048, as introduced, Wicks. Dental benefits and rate review.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes specified coverage and disclosure requirements on health care service plans and health insurers, including specialized plans and insurers, that cover dental services.

This bill, on and after January 1, 2024, would prohibit a health care service plan or health insurer that covers dental services, and a specialized health care service plan or health insurer that covers dental services, from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or preexisting condition provision, as defined, upon an enrollee or insured. On and after January 1, 2024, the bill also would require a health care service plan or health insurer to disclose, at the time of verification for patient eligibility, whether or not the enrollee's or insured's dental coverage is subject to regulation by the relevant department. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

Existing law establishes a process for the Department of Managed Health Care and the Department of Insurance to review proposed rate increases by health care service plans and health insurers in the individual or group market in California. Existing law excludes specialized health care service plan contracts and specialized health insurance policies, among others, from those provisions.

This bill would include health care service plan contracts and health insurance policies covering dental services, and specialized health care service plan contracts and specialized health insurance policies covering dental services, within those provisions. The bill would retain the exclusion with respect to specialized health care service plan contracts and specialized health insurance policies that do not provide dental services. The bill would require the Department of Managed Health Care and the Department of Insurance to establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a specialized health care service plan contract or specialized health insurance policy covering dental services is unreasonable, or not justified, under the applicable requirements of the rate review provisions. By making specialized health care service plan contracts that provide dental services subject to these rate review provisions, the bill would expand the scope of a crime, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1374.194 is added to the Health and Safety Code, to read:

1374.194. (a) The following definitions shall apply for purposes of this section:

- (1) “Dental waiting period provision” means a contract provision that limits coverage for a specified period of time following an enrollee’s effective date of coverage.
- (2) “Health care service plan” means a health care service plan that issues, sells, renews, or offers a plan contract covering dental services or a specialized health care service plans covering dental services.
- (3) “Preexisting condition provision” means a contract provision that excludes coverage for charges or expenses incurred during a specified period following an enrollee’s effective date of coverage, as to a condition for which dental advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(b) On and after January 1, 2024, a health care service plan shall not issue, amend, renew, or offer a plan contract that imposes a dental waiting period provision or preexisting condition provision upon an enrollee.

(c) On and after January 1, 2024, at the time of verification for patient eligibility, a health care service plan shall disclose whether or not the enrollee’s dental coverage is subject to regulation by the department.

(d) This section does not apply to Medi-Cal dental managed care contracts authorized under Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 2. Section 1385.02 of the Health and Safety Code is amended to read:

1385.02. ~~This~~ *(a) This* article shall apply to a health care service plan contract offered in the individual or group market in ~~California~~. *California, including a health care service plan contract covering dental services and a specialized health care service plan contract covering dental services.* However, this article shall not apply to a *nondental* specialized health care service plan contract, a Medicare supplement contract subject to Article 3.5 (commencing with Section 1358.1), a health care service plan contract offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan contract offered in the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article 10.5 (commencing with Section 1399.801), or a Mexican prepaid health plan subject to Section 1351.2. This article does not limit, impair, or interfere with the authority of the California Public Employees’ Retirement System, as set forth in Section 22794 of the Government Code and Article 6 (commencing with Section 22850) of Part 5 of Division 5 of Title 2 of the Government Code.

(b) The department shall establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a specialized health care service plan contract covering dental services is unreasonable, or not justified, under the applicable requirements of this article.

SEC. 3. Section 10120.41 is added to the Insurance Code, to read:

10120.41. (a) For purposes of this section, the following definitions shall apply:

(1) “Dental waiting period provision” means a contract provision that limits coverage for a specified period of time following an insured’s effective date of coverage.

(2) “Health insurer” means a health insurer that issues, sells, renews, or offers a plan contract covering dental services or a health insurance policy covering dental services.

(3) “Preexisting condition provision” means a contract provision that excludes coverage for charges or expenses incurred during a specified period following an insured’s effective date of coverage, as to a condition for which dental advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(b) On and after January 1, 2024, a health insurer shall not issue, sell, renew, or offer a policy that imposes a dental waiting period provision or preexisting condition provision upon an insured.

(c) On and after January 1, 2024, at the time of verification for patient eligibility, a health insurer shall disclose whether or not the insured's dental coverage is subject to regulation by the department.

(d) This section does not apply to Medi-Cal dental managed care contracts authorized under Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 4. Section 10181.2 of the Insurance Code is amended to read:

10181.2. ~~This~~ *(a) This* article shall apply to a health insurance policy offered in the individual or group market in ~~California~~. *California, including a health insurance policy covering dental services and a specialized health insurance policy covering dental services.* However, this article shall not apply to a *nondental* specialized health insurance policy, a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05), a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health insurance policy offered in the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), a health insurance conversion policy offered pursuant to Section 12682.1, a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900), or a Mexican prepaid health plan subject to Section 1351.2 of the Health and Safety Code.

(b) The department shall establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a specialized health insurance policy covering dental services is unreasonable, or not justified, under the applicable requirements of this article.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B LITERATURE REVIEW SPECIFICATIONS

This appendix describes methods used in the literature review conducted for this report. A discussion of CHBRP's system for medical effectiveness grading evidence, as well as lists of MeSH Terms, publication types, and keywords, follows.

Studies of the impact of dental waiting period provisions, pre-existing condition provisions, delayed dental issues, and untreated dental issues were identified through searches of PubMed, the Cochrane Library, Web of Science, and PsycINFO. Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: the Agency for Healthcare Research and Quality (AHRQ), the National Health Service (NHS) Centre for Reviews and Dissemination, the National Institute for Health and Clinical Excellence (NICE), and the Scottish Intercollegiate Guideline Network.

The search was limited to abstracts of studies published in English. The search was limited to studies published from 1980 to present.

Reviewers screened the title and abstract of each citation retrieved by the literature search to determine eligibility for inclusion. The reviewers acquired the full text of articles that were deemed eligible for inclusion in the review and reapplied the initial eligibility criteria.

Medical Effectiveness Review

The medical effectiveness literature review returned abstracts for 569 articles, of which 52 were reviewed for inclusion in this report. A total of 9 studies were included in the medical effectiveness review for AB 1048.

Medical Effectiveness Evidence Grading System

In making a "call" for each outcome measure, the medical effectiveness lead and the content expert consider the number of studies as well the strength of the evidence. Further information about the criteria CHBRP uses to evaluate evidence of medical effectiveness can be found in CHBRP's *Medical Effectiveness Analysis Research Approach*.⁴ To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- Research design;
- Statistical significance;
- Direction of effect;
- Size of effect; and
- Generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention's effect on an outcome. The following terms are used to characterize the body of evidence regarding an outcome:

- *Clear and convincing evidence*;
- *Preponderance of evidence*;
- *Limited evidence*;
- *Inconclusive evidence*; and

⁴ Available at: <https://www.chbrp.org/about/analysis-methodology/medical-effectiveness-analysis>.

- *Insufficient evidence.*

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

A grade of *limited evidence* indicates that the studies had limited generalizability to the population of interest and/or the studies had a fatal flaw in research design or implementation.

A grade of *inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

A grade of *insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

Search Terms (* indicates truncation of word stem)

Caries	Health outcome
Dental bridge	Oral health
Dental crown	Oral health outcome
Dental extraction	Oral health-related quality of life
Dental filling	Oral surgery
Dental preexisting condition	Outcome assessment
Dental waiting period	Periodontal scaling
Denture	Root canal
Delayed dental care	Root planing
Delayed dental issue	Periodontal disease
Delayed dental procedure	Untreated dental disease
Delayed dental treatment	United States or USA

APPENDIX C COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics. Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

AB 1048 will prohibit the use of waiting periods and pre-existing condition clauses. To estimate the impact of this bill, CHBRP considered the following clauses in the analysis:

1. Waiting Periods
2. Missing Teeth Clauses
3. Denture Clauses

Methodology and Assumptions for Baseline Premium and Enrollment

- CHBRP assumed the 2021 average enrollment information by commercial line of business and PPO/HMO from the 2022 National Association of Dental Plans (NADP) Dental Benefits Report.
- CHBRP assumed the 2020 California average premium information by commercial line of business and PPO/HMO from the 2021 National Association of Dental Plans (NADP) Dental Benefits Report. California specific information was available for large group and small group. Total statewide average individual California premium information was estimated based on California small-group premiums and national relativity of premiums between small-group and individual premium.
- Average loss ratios are assumed to be 83.6%, 59.6%, and 58.0% for large-group, small-group, and individual dental PPO plans. They are assumed to be 64.9%, 50.5%, and 60.8% for large-group, small-group, and individual dental HMO plans. These are based on California insurer dental MLR reporting data for 2021 from the publicly available DMHC and CDI web portals.
- Using the assumed loss ratios, the 2020 premium was allocated to covered benefits paid by plan and retention, including administrative expenses, taxes and fees, and profit.
- The 2020 covered benefits paid by plan were trended 3% annually to 2024. The 2024 loss ratio is assumed equal to the 2021 loss ratio. The projected 2024 covered benefits paid by plan and 2024 loss ratio were used to project the 2024 administration/profit and total 2024 premium.
- The 2021 enrollment information was trended to 2024 using a 0% enrollment trend.
- Covered California individual premium and enrollment information is from the 2023 open enrollment renewal profile with data as of February 2023 published on the Covered California website. The 2023 premium and enrollment information were trended to 2024 using the trends, loss ratio and methodology described above.
- CHBRP assumed that, on average, 70% of large- and small-group premiums are paid by the employer and 30% are paid by the enrollee.

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act.
- CHBRP assumed 70%, 90%, and 100% of large-group, small-group, and individual dental PPO plans (respectively) in California have at least some waiting periods or pre-existing condition provisions at baseline.
- CHBRP assumed 0% of HMO dental plans have waiting periods or pre-existing condition provisions at baseline, based on review of industry sources.⁵
- For Covered California individual plans, CHBRP assumed 100% of PPO enrollees and 0% of HMO enrollees have at least some waiting periods or pre-existing condition provisions at baseline.
- CHBRP assumed the baseline dental premiums reflected the baseline percentage of fully-insured California dental plans with waiting periods or pre-existing condition provisions.

Methodology and Assumptions for Baseline and Postmandate Cost Sharing

- CHBRP assumed the average cost sharing for dental services are 20% of total covered benefits at baseline and postmandate.

Methodology and Assumptions for Postmandate Premium

- CHBRP assumed the unit cost for dental services would not change from baseline to postmandate.
- CHBRP assumed an increase to the utilization of dental services due to the removal of waiting periods and pre-existing condition provisions under AB 1048. The utilization increase was reflected as a factor applied to the baseline cost of covered benefits. The factors were developed by line of business and group size by professionals in the healthcare industry who specialize in pricing dental benefits and the 2023 Health Cost Guidelines – Dental.TM Depending on the coverage combination of waiting period, missing teeth clause, and denture clause, the factor applied to the cost of covered benefits ranged from 0% to 5%.

Second-Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 1048 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second-year impacts and determined the second year's impacts of AB 1048 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

⁵ Delta Dental: www1.deltadentalins.com/employers/compare-plans.html, Guardian Direct: www.guardiandirect.com/dental-insurance/no-waiting-period.

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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