

# Key Findings:

## Analysis of California Assembly Bill AB 502 Dental Hygiene

Summary to the 2015-2016 California State Legislature, April 2015



### AT A GLANCE

Assembly Bill AB 502 (introduced February 2015) would require dental PPO plans and insurers that reimburse for dental hygiene services to reimburse Registered Dental Hygienists in Alternative Practice (RDHAP) as out-of-network providers without any separate registration process. AB 502 would not require dental plans and insurers to contract with RDHAPs as in-network providers, nor would AB 502 require direct reimbursement to RDHAPs.

- **Enrollees covered.** CHBRP estimates that in 2015, 8.34 million Californians have state-regulated dental coverage with access to dental hygiene services through their standalone or embedded dental benefit.
- **Impact on expenditures.** CHBRP provides two estimates on expenditures, derived in part from two different data sources that generated its baseline expenditure estimates. Estimate A projects total net annual expenditures to increase by \$47,236 (0.001% in PMPM). In Estimate B, the projected increase in total net annual expenditures would be \$1.944 million (0.04% in PMPM).
- **EHBs.** No impact on the essential health benefits (EHB) pediatric dental coverage requirement for children is expected, nor any EHB costs for the state to defray.
- **Medical effectiveness.** CHBRP found a preponderance of evidence from moderate quality research that the services potentially provided by RDHAPs are effective in alternative practice settings, such as schools, homes of homebound, institutions, and shortage areas. Although CHBRP is unable to estimate health benefits from AB 502 quantitatively, it stands to reason that access to effective oral health care would improve health outcomes among these populations.
- **Public health.** While patients in alternative practice settings would be likely to experience improved oral health outcomes, the effect that AB 502 would have on health disparities by gender, race, and ethnicity among the RDHAP patient population is unknown.

- **Long-term impacts.** The reductions in administrative barriers associated with RDHAP practice, including problems with reimbursement, may result in increasing numbers of RDHAP licensees and greater willingness to provide services to vulnerable populations. Thus, the long-term effects would likely increase access to dental health services and consequent improvement in dental health for patient populations in RDHAP practice settings. However, the number of patients impacted is small, thus the magnitude of public health outcomes is also small.

### BILL SUMMARY

AB 502 (as introduced on February 23, 2015) would amend the Health and Safety Code (H&SC) and Insurance Code (IC), requiring health plans and policies that cover dental services, including specialized health plans and policies, to:

- Allow a registered dental hygienist in alternative practice (RDHAP) to submit any claim for dental hygiene services performed as authorized in the California Business and Professions Code (B&PC).<sup>1</sup>
- Reimburse an RDHAP for dental hygiene services that may be performed by a registered dental hygienist (RDH) under the B&PC if the plan or policy provides reimbursement for dental hygiene services.
- Use the same fee schedule for dental hygiene services whether they are performed by an RDH or an RDHAP.

Further, AB 502 would amend the B&PC<sup>2</sup>:

<sup>1</sup> Business and Professions Code (B&PC), Division 2, Article 9, Chapter 4.

<sup>2</sup> In a subsequent amendment to AB 502 on April 16, 2015, both the DHPA continuation language and removal of the 18 month written verification requirement were deleted from the bill ([http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab\\_0501-0550/ab\\_502\\_bill\\_20150416\\_amended\\_asm\\_v98.html](http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0501-0550/ab_502_bill_20150416_amended_asm_v98.html)).

- Requiring that an alternative dental hygiene practice established in a dental health professional shortage area (dental HPSA) continue regardless of certification.
- Removing the requirement that an RDHAP who has seen a patient for 18 months or more obtain a written verification, including a prescription for dental hygiene services, that a patient has been examined by a licensed dentist, physician, or surgeon.

## CONTEXT FOR BILL CONSIDERATION: RDHAPS

With the goal of improving access to dental services for underserved populations, California formally recognized a new category of dental care professional in 1998 — RDHAPs. RDHAPs are registered dental hygienists (RDHs) in the state of California with bachelor's degrees (or equivalent certifications), who have completed a continuing education course in independent practice dental hygiene and passed a licensing examination administered by the Dental Hygiene Committee of California (DHCC). Once licensed, DHCC requires RDHAPs to designate a "dentist of record" for referrals, consultations, or emergencies, after which RDHAPs are able to provide dental hygiene services without the supervision of a dentist to underserved populations in alternative practice settings, which are schools, residential and other institutions, residences of the homebound, and dental health professional shortage areas. According to DHCC there are currently 563 RDHAPs licensed to practice in specified alternative settings, which include residences of the homebound, schools, residential and other institutions, and dental HPSAs.

Currently, while no other states have legislation focused on reimbursement as AB 502 is, many states are looking at requirements around scope of practice for dental hygienists (note: AB 502 does not change RDHAPs scope of direct dental services rendered). These bills are primarily focused on modifying existing requirements for or allowing registered dental hygienists to practice under nondirect supervision of dentists in alternative settings. In some cases, the legislation is focused on expanding services registered dental hygienists are able to provide without direct supervision of a dentist.

## Incremental Impact of Assembly Bill AB 502

### Benefit Coverage, Utilization, and Cost

#### Benefit Coverage

##### *Premandate (baseline) benefit coverage*

Currently, all 8.34 million enrollees subject to AB 502 have access to dental hygiene services through their standalone or embedded dental benefit. CHBRP's findings also concluded that:

- There are not currently any RDHAPs that participate as contracted network providers in dental HMOs (DMO) or dental PPOs (DPPO) in California. Thus, CHBRP estimates that 5.25 million (62.9% are estimated to be in DPPO plans, in which RDHAPs can currently submit claims for services delivered as an out-of-network provider.

AB 502 would require several changes that have utilization and cost implications for services delivered and billed to private, state-regulated dental PPOs in California.

#### Utilization

##### *Premandate (baseline) utilization*

Premandate, 100% of enrollees (8.34 million) have benefit coverage for dental hygiene services, including cleanings, x-rays, preventive services, and fluoride treatment for children. However, only 53.6% of enrollees were in state-regulated DPPOs that currently reimbursed all out-of-network RDHAP claims.

Due to conventional data availability constraints, CHBRP used two different approaches to calculate the impact of AB 502.

##### *Postmandate utilization*

Postmandate, it is expected that all RDHAPs providing care to any of the 5.25 million state-regulated, private dental PPO enrollees would be reimbursed for services, if provided out of network.

## Estimate A

CHBRP calculated in Estimate A that reimbursement of RDHAP services is estimated to increase among enrollees in plans that did not previously reimburse by 0.24 visits per 1,000 enrollees, for an increase of 674.8 reimbursed visits annually (a 116% increase).

Despite the limits of the calculation above and limited data, the increase described above provides a better understanding of the limited impact of AB 502 on utilization and cost, given the narrow definition of alternative practice, the low number of RDHAPs practicing, and the small number of privately insured individuals who seek care in alternative practice settings.

## Estimate B

Using data from on the number of RDHAPs in various practice settings (see Table 2 on page 9 of the report), and the percentage of patients likely to be privately insured (10%), CHBRP estimated that all 27,768 services provided by RDHAPs were unreimbursed by state-regulated private DPPO plans (46.4% of the 59,844 total visits provided by RDHAPs). Although the utilization of visits would not change based on these data, the RDHAPs delivering these services would be reimbursed for 27,768 additional hygiene visits (87% increase).

## Expenditures

### *Premandate (baseline) expenditures*

In Estimate A, using the baseline utilization estimate of 0.24 visits per 1,000 enrollees in plans that covered RDHAP services already, the total expenditure per year is \$40,885. Of that, it is estimated that 20% is out-of-network cost sharing, so the expenditure by DPPO carriers is \$32,709.

In Estimate B, using the baseline utilization estimate of 32,076 reimbursed visits to RDHAPs and an average cost of \$70 per visit, the total expenditure per year is \$2,245,347. Of that, it is estimated that 20% is out-of-network cost sharing, so the expenditure by DPPO carriers is \$1,796,278.

## *Postmandate expenditures*

### *Changes in total expenditures*

According to Estimate A, AB 502 would increase total net annual expenditures by \$47,236 or 115.5% for enrollees with DMHC-regulated plans and CDI-regulated policies. The increased spending will be partially paid for by DPPO carriers (\$37,779) while the remaining \$9,457 will be from patient cost sharing for out-of-network services (20%).

According to Estimate B, AB 502 would increase total net annual expenditures by \$1,943,760 (87%) due to the 27,768 newly reimbursed RDHAP services. At \$70 per visit, and assuming one visit being reimbursed per year, this represents an 86.6% increase in spending. \$388,752 (20%) of the spending would be paid for by enrollees due to out-of-network cost sharing, while the remainder (\$1,555,008) would be paid for by DPPOs that did not previously reimburse all or part of RDHAP claims.

Based on an average dental insurance per member per month premium of \$39.30 among the 8.34 million enrollees in state-regulated plans, the additional expenditure in Estimate A would translate to a 0.001% increase in premiums.

In Estimate B, the increase in total net annual expenditures for DPPO plans would be \$1,555,008 after patient cost sharing. Based on a \$39.30 dental PMPM for the 8.34 million enrollees in state-regulated plans, the additional expenditure in Estimate B would translate to a 0.04% increase in premiums.

## **Related Considerations for Policymakers**

### **Cost of exceeding essential health benefits**

As explained previously, dental hygiene services are already included in California's EHB package for children in 2015 and 2016. The state is required to defray the additional cost incurred by enrollees in QHPs in Covered California for any state benefit mandate that exceeds the EHBs. Because dental hygiene services delivered by RDHAPs are already a covered benefit and AB 502 focuses on codifying payment levels and expectations for out-of-network RDHAP providers, the law will not impact the EHBs.

## Public Health

Although the bill's focus is on the lack of reimbursement for some RDHAPs providing care to a small number of privately insured patients residing in shortage areas or seeking care through alternative settings, it will impact coverage for approximately 46.4% of those with private dental coverage regulated by the state. Little is known about current attempts by RDHAPs to collect reimbursement from out-of-network plans, or the cost sharing their patients may be exposed to. However, this bill would codify the requirement that all RDHAPs should receive reimbursement for services provided out of network in DPPO products regulated by the state, which could decrease barriers to reimbursement, patient utilization, and change perceptions and business practices for RDHAPs.

## Long-term Impacts

The reductions in administrative barriers associated with RDHAP practice may result in increasing numbers of RDHAP licensees. Thus, the long-term effects would like increase access to dental health services and consequent improvement in dental health for patient populations in RDHAP practice settings. However, the number of patients impacted is small, thus the magnitude of public health outcomes is also small.

## Medical Effectiveness

CHBRP's Medical Effectiveness review presents findings of studies relevant to both the provision of dental services in general, and by RDHAPs specifically. These services included: (1) preventive interventions (dental sealants and oral hygiene education); (2) therapeutic interventions [prophylaxis (teeth cleaning) and periodontal maintenance (root planning and the application of fluoride)]; and (3) diagnostic services (oral health screenings). CHBRP's review also describes evidence on the effectiveness of providing oral hygiene services in the settings in which RDHAPs most typically provide those services.

CHBRP found a high degree of evidence from studies with moderate to strong research designs that preventive interventions such as topical dental sealants, fluoride applications, and dental health education are effective in improving oral health outcomes such as the prevention of tooth decay, caries, and the loss of tooth enamel.

CHBRP found ambiguous evidence from studies with weak to moderate designs that prophylaxis (teeth cleaning) and scaling are ambiguously effective in improving oral health outcomes such as plaque, gingivitis, caries, and periodontal disease.

There is a preponderance of evidence from studies with weak to moderate designs that periodontal maintenance is highly effective in controlling or slowing the progression of existing periodontal disease.

One of the most basic functions served by the RDHAP model is the potential to provide services in alternative settings. These settings are generally defined by population density and population to dentist ratio. However, the mobility of the RDHAP also lends itself to the ability to provide services in school, work, institutional, or residential settings. There have been very few specific studies examining the impact of these alternative settings; however, it should be noted that there have been very few specific studies examining the impact of RDHAPs providing these services in these settings. Although there is such a limited body of evidence available, it stands to reason that the effectiveness of these services would not be different to those provided in the environment of a dental office. The distinction between alternative practice settings and more traditional settings is unlikely to impact patient care, and has more to do with the type of patient seen by RDHAPs (i.e., vulnerable, uninsured, Medi-Cal) and less to do with the care provided in each setting.