Committee Minutes

Date: May 13, 2003
Time: 8:30 a.m.
Room: 101 LOB

The Senate Committee on Insurance held a hearing on the following:

HB 316-FN relative to insurance coverage for anesthesia for child dental care.

Members of Committee present:
Senator Flanders
Senator Prescott
Senator Cohen
Senator Martel
Senator Rebergé

The Chair, Senator Robert B. Flanders, opened the hearing.

I'd like to open the hearing on HB 316-FN. I recognize the prime sponsor Representative Larry Emerton.

Representative Emerton: Good morning Mr. Chairman and members of the committee. I'm Representative Larry Emerton, Goffstown, District 48. This bill I was introduced by myself and others and it's been amended by the House and we have experts here behind me who will tell you all about it in detail and give you story of what is going on here. As I remember from several weeks ago when it passed, the request was to increase the anesthesia for children up to age 8. If I remember correctly it's been changed to age 6. That was a compromise in the commerce committee. It passed the House if I remember on consent calendar. There was no discussion there. There was also no discussion in the finance committee, which I'm a member of. That's where it stands.

Senator Robert B. Flanders, D. 7: Questions? I have one and you maybe want to defer. The bill says that who is determined by a licensed dentist in connection with a licensed physician.

Representative Emerton: A licensed physician? I think I will let the experts answer that Senator Flanders.

Senator Robert B. Flanders, D. 7: Thank you for your testimony.

Representative Emerton: Thank you.

Senator Robert B. Flanders, D. 7: Any one of you gentlemen.

I'm Dr. Doug Johnson. I'm a children's dentist in Concord. I've practiced here for thirty years. I guess there was some confusion earlier. The bill does not cover the insurance coverage for the dental work. The bill covers the hospital related expenses. Anesthesia, recovery room, nurse's fees, that kind of thing. The purpose of the bill is not to cover dental treatment.

Let me just pass this around. The type of treatment that we're talking is not your usual dental fillings. These are young two, three and 4 year olds with rampant decay. This is stuff that is very serious and it can only be treated in the hospital. You'll see some photographs where the teeth had to be removed, stainless steel crowns put on. It's extensive work that we just can't do in the office. Most of the kids that have this early childhood decay come to us from emergency rooms, from their pediatricians, maybe from a general practitioner. They tend to be quite young, generally around two or three. Many or most of the kids we end up treating when they are very, very young. The current status quo covers a lot of the kids where there's insurance coverage under the age of 4. Some of the kids seem to slip through the cracks. We may not see them until they are 4, five or even 6. They still need a lot of work. A lot of them are still very, very scared and we just can't do that kind of work in the office. That's why they are put in the hospital and we treat them under general anesthesia.

The fact that the age is being increased from kid under 4 to kids under 6, that increases the age by 50%. It adds two years. It's not going to increase the number of patients being treated by 50% because most of them have already been treated. They're very young. They're usually two or three. I can't tell you what the number of patients would be. My guess is it would be about, I see about an average of 4 kids a month that I have to treat in the hospital and my guess is that it might add one more patient.

So there's not going to be a tremendous number of kids getting treatment and therefore causing a big increase in insurance premiums.

The other point I want to make. As I understand, it's the only bill so far this year that has been passed by the commerce committee. So they feel it has a certain amount of merit.

The last thing that I wanted to give you and I think Dr. Stoops is going to talk on this to some extent. This is a summary of the other states that have anesthesia bills. There are either 28 or 30 states, New Hampshire and Connecticut that have under 4 as an age limit. As you look at that chart on the top you'll see as you go across there are a number of states that have five, seven, 8, nine, nineteen and then there are five states that have no age limit. As I understand it Connecticut has a bill that is being considered at this time to also increase the age.

I think it's an important bill. I was totally for it when it used 8 or under 8 as the limit and I'm still very much in favor of it for using 6 as the age limit. The printed material under the cover sheet is information I summarized for you on the front page. That's from our American Academy of Pediatric Dentistry Council on Benefit Programs.

Do you have any question?

Senator Robert B. Flanders, D. 7: Anyone have any questions? I have one. Where do you practice please?

Dr. Johnson: Concord.

Senator Robert B. Flanders, D. 7: I'm surprised by your testimony that you see in a month's time 4 children that need to be admitted to the hospital.

Dr. Johnson: Yes, probably three or 4 per month. I've practiced for 30 years and it has remained fairly constant.

Senator Robert B. Flanders, D. 7: I'm not sure if you can answer my next question. If someone allows teeth to get into the situation that you showed us in those pictures, which are terrible, will they have insurance?

Dr. Johnson: A lot of the kids are on medicaid. I don't know what the percentage is but I would say it's over 50%. So this bill doesn't really affect them. They're already being covered.

Senator Robert B. Flanders, D. 7: This bill wouldn't affect them. Can you give me an estimate approximately is?

Dr. Johnson: Anesthesia, the hospital?

Senator Robert B. Flanders, D. 7: You're talking about the anesthesia, the recovery room, the nurses?

Dr. Johnson: It runs around $2,500. It tends to be more expensive than the actual dental care, which is kind of interesting. It's a real burden for parents that already have medical insurance but it doesn't cover this if the kids are older than 4. That's a big problem.

Senator Robert B. Flanders, D. 7: I have one last question and I don't know if it should go to someone else. Do we know whether insurance is offered now for above 4 years old? I know the mandate is 4.

Dr. Johnson: No.

Senator Robert B. Flanders, D. 7: Can they buy over 4? No they can not. Thank you. Any other questions?

Senator Russell E. Prescott, D. 23: How many other dentists in Concord who do the kids work in the hospital?

Dr. Johnson: There are three of us. I have a young partner, myself and there is another practitioner.

Senator Russell E. Prescott, D. 23: No other firms.

Dr. Johnson: Not in Concord. It's something that is done by pediatric dentists. There are maybe 16 in the state that actually treat children in the hospital.

Senator Robert B. Flanders, D. 7: So if a local dentist finds a young person with problems they are referred to you or someone like you. The bill states that this decision be made by a licensed dentist in conjunction with a licensed physician. How does that fit in?

Dr. Johnson: I don't know. The original bill that passed about 4 years ago had that language removed. In other words it was our determination that they needed the care in the hospital and that they wouldn't have to go to a physician to have the same thing determined. It would just make it more cumbersome and more expensive. I don't know. Do you Jim know if that is other wording than is already on the books? That did come up years ago on the original bill and it was altered so it wouldn't be so cumbersome so that they wouldn't have to go to a dentist and to a physician and he would say "yes the teeth are rotten" and he's 2 or 3 and it needs to be done in a hospital.

Senator Robert B. Flanders, D. 7: Can you explain to us now what you do now between, over 4 years old who come to you with teeth that look like the photographs that you showed us?

Dr. Johnson: We might put some temporary fillings in. We might send them to an oral surgeon and they just take out the teeth that are starting to bother them. If you notice some of the photographs we've put caps on the teeth and save them. There's not a lot that we can do if they're uncooperative and scared and they need this kind of work. They end up going on penicillin, antibiotics. We might be able to do a little bit of work and they end up having a lot of teeth removed by the oral surgeon.

Senator Robert B. Flanders, D. 7: If they go to an oral surgeon to have the teeth removed, anesthesia is not a question?

Dr. Johnson: Anesthesiologists will give them anesthesia in their office.

Senator Robert B. Flanders, D. 7: Because of their training?

Dr. Johnson: Because of their training. The problem is that they don't end up getting comprehensive care. They just have teeth removed.

Senator Robert B. Flanders, D. 7: That first picture that you showed us, I can't believe that you can do anything to repair those?

Dr. Johnson: Those teeth were abscessed and if you notice they had to be removed. The upper front teeth and all the teeth in the back were capped. The other ones showed teeth that looked pretty bad but they could be saved.

Senator Burton J. Cohen, D. 24: I was just wondering why it has been at 4 as opposed to 6? How has it stayed there? What was the motivation to leave it at 4 instead of 6?

Senator Robert B. Flanders, D. 7: The bill got defeated last year.

Dr. Johnson: It was introduced to go to 8 and it got downgraded as it went through the legislative process.

Senator Robert B. Flanders, D. 7: Any other questions of this witness? Thank you for your testimony.

Dr. Ward Stoops, Pediatric Dentist: Good morning. I am Dr. Ward Stoops, I am a pediatric dentist also. I have been here a little bit longer than Doug. I

have been here 33 years, but I have been at it almost 50. My concern is that there are certain children who fall through the cracks. We did get 4 years, which was a step in the right direction. We hoped much more to get 6 or 8 the first time through but the insurance people convinced the committee that this would be a disaster. We don't feel it has been. The other point I want to bring out, the insurance representative last time we had a hearing in the House said that the insurance adjusters said it would double fees for the insurance because they increase the age from 4 to 8. As Dr. Johnson mentioned, the number of kids we have at over 4 who have to have this kind of work are much fewer than the ones under 4. The majority of those children can be worked on in the chair because they're old enough to understand what is going on.

But there are exceptions to that. One of the cases I think that comes to mind is the child that was borderline problem with psychosis and the diagnosis was made that the child would get hysterical in the chair and you couldn't do a thing with him at all. Yet the child was over 4 and we could not put him in the hospital and the child went without care for a long time. There are specific reasons for specific children. I think the general feeling among our group is that we don't put a child in the hospital unless we have to. It's a last resort. We'd much rather help them understand what's going on and help train them to be good dental patients. Sometimes you have to do this initially to get the big jobs out of the way so that later they can get over their fears and become good dental patients as they get older. We don't want children to go through life as many adults do with fear of dental work so that whey they get in the chair they break out in a cold sweat and avoid dentistry until real problems occur.

Another reason we want to go up in age is that by the age of 6 most of the children have their first permanent molars. We'd rather have it at 8 because they'd all have their permanent molars and these are the key teeth in the arch that prevent orthodontic problems. They are just the key permanent teeth that we want to preserve and they often come in with a lot of flaws in them, areas that decay very rapidly through no reason or lack of care. They just come in that way. One of the other problems we have with young children are there are certain families that have very poor teeth. It's just inherited. These pictures that Doug showed are not always the case of neglect. They are the case of inherited tendencies and the bacteria that live in the mouth, certain mouths cannot be controlled without extensive dentistry.

I also have summarized some of the material that came out of the Academy of Pediatric Dentistry. It just shows you averages. I did a little bit of calculation. It shows the number of states that have coverage at different

levels and it shows that we're not out of step. In fact, we're probably much below average of the country of the 30 states that do have coverage for anesthesia and hospitalization for children. In column one I put the age covered up to and column two is the number of states that have that coverage and column three I've taken a factor, dividing these so we get a factor. So if you divide the total number into that factor you get an average of 9 years for all 30 states. If you take half of the mean, which is half above and half below it comes between 7 and 8. So we're not out of line if we do get the 6. In fact we're still below average for the country. The other concern I have is that we and that bill does require a physician's permission. One, the physician frequently doesn't know how the child is going to react in the dental chair or has reacted in the dental chair. It's an added burden for them to have to write the letter. It's an added burden for us to have to bother them. So I think that while it will probably go through with the bill, I think it's an unnecessary problem because we're the ones that evaluate the dental problems and understand them. The physicians have a lot of other areas that they have to cover and be concerned with and I don't think that they have the touch contact that we have with the need on these children. I wish it weren't there but if it's there it will allow these children to get dental care because money won't be an impediment.

That's basically all I have to say. If I can give any more information I'd be happy to.

Senator Robert B. Flanders, D. 7: Any questions of the witness?

Senator Sheila Roberge, D. 9: If you admit this child you will work on this child in the hospital?

Dr. Stoops: We admit them to the hospital like it were a major surgical case. They are actually put to sleep by an anesthesiologist, a physician, in our hospital it is a physician, it can be a nurse anesthetist in the OR and all the work is done within the sleep, intubated so there is no risk of aspiration. The children recover very quickly. It's very easy on the children. We usually bring them in at 7:30 in the morning and they can go home by noon. We've had kids with all those teeth that you saw taken out eating pizza that night. It's amazing. These were children that were in pain, couldn't eat properly, couldn't chew, stayed away from cold beverages or warm things because their teeth hurt and a day or two later they are right back eating better. There's been lots of studies showing they gain weight. They do better is school. Their self-image is better. It's improved so that all the way around these children make a magnificent recovery from a problem that has been dogging them for a long time.

Senator Robert B. Flanders, D. 7: Any other questions of this witness? I have just one sir. It appears from your testimony that an awful lot of this is behavior rather than pain. Is that correct?

Dr. Stoops: It's a combination. Some of those children are in pain and some of them are not. We're trying to save the teeth one way or another. It's either with the very young children it's behavior because they're too young to understand what's going on and be able to cooperate with these long procedures. The older children it's usually a case of fear. Sometimes it's siblings who have scared them by telling them gruesome stories of dentistry or the parents doing the same thing and they're just prime to be fearful of any work in the mouth. That varies a lot with the individual child.

Senator Robert B. Flanders, D. 7: Any other questions? If not, thank you for your testimony. Liz Murphy.

Elizabeth Murphy, representing HIAA and Cigna Healthcare: I'm here today representing HIAA and Cigna Healthcare. While we're not taking a position on the bill, as my clients reviewed legislation proposed for this year and once again so a number of mandated benefits proposed while they were also working with the same legislature to bring down the cost of health care in SB110, they discussed with me the approach that other states have taken to begin to look carefully at the effects of mandates and the real impacts on the social and economic effects of those mandates. So in speaking with some of you and hearing some degree of interest for the same I've provided the committee today with a copy of an amendment to this bill that I thought might be helpful. It is a copy sort of done in "New Hampshirese" of what's being done in many states across the country where it would appear that the numbers of mandates coming before the legislature are so significant that perhaps time ought to be taken apart from the legislative process to determine what the actual costs are. This council wouldn't have the ability to stop a piece of legislation but it would upon filing be sent to this council to be researched for the time and have the council come back with a report with what the actual costs and the benefits are of that particular mandate. While there are a couple of things that are in here that are scooped right out of the Virginia law. One is that in Virginia when they put in effect the special council on mandated health benefits they decided to look at the current benefits also. I think that might be a grand undertaking and for the beginning you might want to consider, I hope you would consider putting a council like this into place to look at proposed mandated benefits that might be coming in next year or the next session after that.

Senator Robert B. Flanders, D. 7: Any questions of this witness? Thank you for your testimony.

Ms. Murphy: Thank you for your consideration.

Mr. James Bianco, representing the New Hampshire Dental Society: I'm here in support of the bill. I just want to answer the question that you had mentioned earlier Senator Flanders about why the reference in the bill to the physicians. The subcommittee in the house and in the commerce committee there was a lot of discussion about the cost. The numbers that came in were all over the board. So the committee felt, I think it was Mr. Hunt that suggested this, but perhaps not, but the committee felt that what they would need was a check almost like what you have now with your primary care physicians. Now you call your primary care physician so they inserted this language trying to get some control over the numbers. You'd have to involve your primary physician. That's why it was there. Just to explain to you that part of it.

The other part of it is back in 2000 the committee when they passed the original bill asked the insurance department if they could put together some estimated numbers and Commissioner Paul Rogers put together a letter which he sent at that point to the speaker, the governor and the president of the Senate. It's very short but I'm not going to read it to you. The last sentence says the insurance department has not been able to determine any significant impact has occurred to the cost of health and dental insurance in a group market since the passage of this legislation. So the legislation passed. She was asked to go look at the cost. She did and this is the letter that she did and this is the latest information that we have from the department on the issue of cost. While I know that is not the purview of this committee I'm sure your interest is how much we're talking about.

Finally Mr. Chairman in respect to Ms. Murphy's amendment we have not had a chance to see it and the only thing I can say is that it's a clean bill. It's going to help some children. We don't want to weigh it down with any kind of amendment that is going to cause it to have problems. So perhaps if that's a viable issue that she has perhaps it's another bill that it could go on so that this could go along and we could help these children.

I appreciate your time.

Senator Robert B. Flanders, D. 7: Any questions of this witness? If not thank you for your testimony. Is there anyone else who wishes to speak on HB 316?

Dr. Stoops: May I make one more comment? Just to back up what Dr. Johnson said. Of this increase, causing a significant increase in the number of the children that we have to hospitalize, my guess is that one out of every

five that we do have to hospitalize would be over the age of four anyway. It would be a very small impact. Most of those children we do work with them and a lot of those older children can be helped by various methods of fearly, abatement and help, so I don't think it's a big change in the overall picture.

Senator Robert B. Flanders, D. 7: If no one else wishes to speak, I'm going to close the hearing on HB 316-FN.

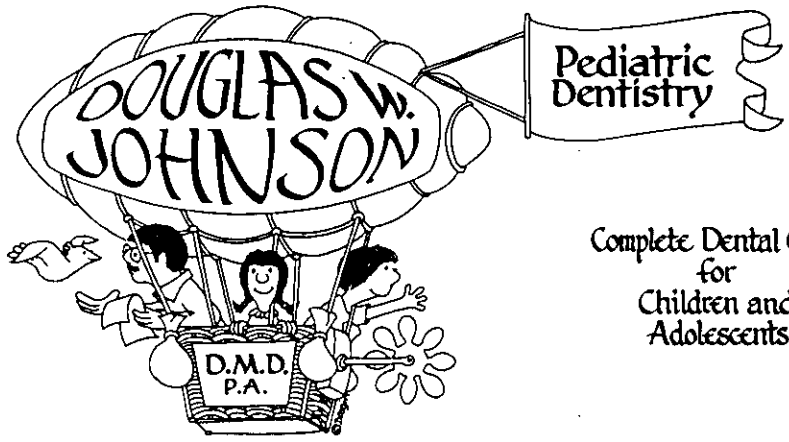
Hearing closed at 8:55 a.m.

Respectfully submitted

Pamela Manocchi
May 22, 2003

attachments

5/13/03



Complete Dental Care for Children and Adolescents

Summary of Enacted General Anesthesia Legislation by age and state for children Requiring Dental Treatment:

Under 4	5	7	8	9	19	NO AGE LIMIT	6
CT	1. IA	1. CA	1. FL	1. NC	1. IN	1. ME	1. IL
*NH	2. KS	2. GA	2. MD	2. ND		2. LA	
	3. MN	3. WA	3. NE	3. OK		3. MS	
	4. MO			4. TN		4. TX	
	5. NJ			5. Ky		5. Co	
	6. SD						
	7. VA						
	8. WI						

"Mental or physical condition that necessitates general anesthesia" (NO AGE LIMIT)

1. LA
2. MS
3. TX
4. CO
5. Maine

Total States: 28

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MEMBER OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

* From AADP Council on Benefit (Dental) Programs (Fall 2002)

AAPD Council on Dental Benefit Programs *Fall 2002*

Summary of Enacted General Anesthesia Legislation

State	Year	Patient Populations Affected	Who defines need	Location	Other
Calif.	1998	• Child under age 7 years • Developmentally disabled patient regardless of age • Medically compromised patient regardless of age	Not specified	Hospital or surgical center	
Colo.	1998	"Child" is specified but not defined. • Child with a physical, medical or mental compromise • Local anesthesia is ineffective due to acute infection, anatomic variation, or allergy • Child or adolescent is extremely uncooperative, unmanageable, anxious or uncommunicative with dental needs that cannot be deferred • Child that has sustained extensive orofacial and dental trauma	Treating dentist	Hospital, surgical center or other facility specified under a particular Colorado Statute	Can limit providers to pediatric dentists or other dentists with hospital privileges. Excludes TMJ treatments
Conn.	1999	• Child under the age of 4 determined to have a dental condition of "significant dental complexity" that it requires certain dental procedures to be performed in a hospital • Person who has a developmental disability that places the person at serious risk	Treating dentist or oral surgeon and the patient's primary care physician	Hospital (law covers inpatient dental services only)	
Fla.	1998	• Child under age 5 years with a significantly complex dental condition or a developmental disability in which management in the dental office has proved ineffective • Patient (no age specified) with one or more medical conditions that would create significant or undue medical risk if dental treatment were not rendered in a hospital or ambulatory surgical center	Licensed dentist and the child's physician	Hospital or surgical center	
Ga.	1999	• Child 7 years of age or younger • Developmentally disabled patient regardless of age • Individual for whom a successful result cannot be expected for dental care under local anesthesia due to a neurological or medically compromising condition • Individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance	Not specified	Hospital or ambulatory surgical facility	Can limit providers to pediatric dentists or other dentists with hospital privileges
Ill.	2002	• Child age 6 or under • Individual with a medical condition that requires hospitalization or general anesthesia for dental care • Individual who is disabled	Not specified	Hospital or ambulatory surgical treatment center	Modeled after Wisconsin law.
Ind.	1999	• Child less than 19 years of age. • Individual with a physical or mental impairment that substantially limits one or more major life activities	Not specified	Hospital or ambulatory surgical setting	• References AAPD guidelines on general anesthesia indications

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State	Year	Patient Populations Affected	Who defines need	Location	Other
					• Can limit providers to those with hospital privileges • Excludes TMJ treatment
Iowa	2000	• Child under 5 years of age with a dental condition or developmental disability for which management in the dental office has proved to be ineffective • Any individual with one or more medical conditions that would create significant or unique medical risk unless dental treatment is rendered in a hospital or ambulatory surgical center	Licensed dentist and the treating physician	Hospital or ambulatory surgical center	
Kan.	1999	• Child five years of age and under • Person who is severely disabled • Person with a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided	Not specified	Not specified	Insurer may apply deductibles, coinsurance, network requirements, medical necessity determinations, and other limitations as applied to other covered services.
Ky.	2002	• Child less than 9 years of age • Individual with serious mental or physical condition • Individual with significant behavorial problems.	Admitting physician or dentist	Hospital or ambulatory surgery facility	Insurer may apply deductibles, coinsurance, network requirements, medical necessary provisions and other limitations as applied to other covered services.
La.	1997	• Insured with a mental or physical condition that requires dental treatment to be rendered in a hospital setting based on AAPD guidelines	Dentist	Hospital	Can limit providers to pediatric dentists or other dentists with hospital privileges. Excludes TMJ treatments
Maine	2001	• Physical, intellectual or medically-compromising conditions • Dental treatment needs for which local anesthesia is ineffective • Extremely uncooperative, fearful, anxious or uncommunicative children and adolescents • Extensive oral-facial or dental trauma	Not specified	Hospital	
Md.	1998	• Patient under age 8 years or developmentally disabled for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia • Patient who is extremely uncooperative, fearful or uncommunicative, is under age 18 years, and has dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth or other increased oral or dental morbidity	Not specified	Hospital or ambulatory facility	Can limit providers to pediatric dentists, oral surgeons or other dentists with hospital privileges. Excludes TMJ treatments

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State	Year	Patient Populations Affected	Who defines need	Location	Other
Minn.	1995	• Child under age 5 years • Patient who is severely disabled (no age specified) • Patient who has a medical condition and who requires hospitalization or general anesthesia for dental care treatment	Not specified	Hospital or dental office	
Miss.	1999	• Child with a mental or physical condition requiring general anesthesia for dental care • Mentally handicapped adult requiring general anesthesia for dental care	Dentist	Hospital, surgical center or dental office	• Stipulates that general anesthesia must be physician-supervised • Coverage is optional; each insured must accept or reject it in writing and accept responsibility for premium payment • Insurer may require a medical necessity review • References AAPD guidelines on general anesthesia indications • Excludes TMJ treatments
Mo.	1998	• Child is under age 5 years • Patient is severely disabled (no age specified) • Patient with a diagnosed medical or behavioral condition which requires hospitalization of general anesthesia when dental care is provided	Not specified	Hospital or surgical center	
Neb.	2000	• Child under 8 years of age • Patient who is developmentally disabled	Insurance company as defined by the group policy, contract or benefit plan	Hospital or ambulatory surgery center	Insurer may apply deductibles, coinsurance, network requirements, and prior authorization as specified in the group policy, contract or benefit plan
N.H.	1998	• Child under age 4 years with a dental condition of significant complexity which requires treatment under general anesthesia • Patient with exceptional medical circumstances of a developmental disability that places patient at serious risk	Licensed dentist and licensed physician	Hospital or surgical day care facility	Requires the insurance department to report on costs by January 1, 2000
N.J.	1999	• Child age 5 or under • Person who is severely disabled (no age specified)	Not specified	Coverage is provided "regardless of where dental services are provided"	
N.C.	1999	• Children below the age of 9 years	Provider treating the patient	Hospital or ambulatory surgical	Insurer may apply deductibles, coinsurance, network

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State	Year	Patient Populations Affected	Who defines need	Location	Other
		• Persons with serious mental or physical conditions • Persons with significant behavioral problems		facility	requirements, medical necessity determinations, and other limitations as applied to other covered services.
N.D.	1999	• Child under age 9 years • Patient who is severely disabled • Patient who has a medical condition that requires hospitalization or general anesthesia for dental care	Not specified	Hospital or ambulatory surgery center	
Okla.	1998	• Patient (no age specified) who is severely disabled • Child under age 9 years with a medical or emotional condition which requires hospitalization or general anesthesia for dental care	Not specified	Hospital or ambulatory surgical center	
PR	1999	No information available			
S.D.	1999	• Child under age 5 years • Patient who is severely disabled or suffers from a developmental disability which places such a person at serious risk	Licensed physician	Hospital or dental office	
Tenn.	1996	• Child under age 9 years for whom treatment cannot be performed safely in a dental office setting	Not specified	Hospital	
Texas	1996	• Patient (no age specified) who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental or medical reason	Patient's physician or the treating dentist	Not specified	
Va.	2000	• Child under 5 years of age • Patient who is severely disabled • Patient who has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care	Licensed dentist in consultation with the patient's physician	Hospital or outpatient surgery facility	
Wash.	2001	• Child under 7 years of age • Physically or mentally disabled • Medical condition that would place the person at undue risk if dental procedure were performed in a dental office	Physician must determine medical condition risk and approve procedure	Hospital, medical or ambulatory surgical center	Dental coverage plans must cover general anesthesia provided in the dental office in conjunction with any covered dental procedure for child under age 7 or any person physically or mentally disabled
Wis.	1997	• Child under age 5 years • Patient with a chronic disability • Patient with a medical condition that requires hospitalization or general anesthesia for dental care	Not specified	Hospital or ambulatory surgical center	

** All laws permit the insurance carrier to require prior authorization for this coverage.

AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

SUMMARY OF ENACTED GENERAL ANESTHESIA LEGISLATION AS OF 2/18/03

Column 1 AGE COVERED UP TO	Column 2 NUMBER OF STATES	Column 3 COLUMN 1 X 2	SUMMARY Column 3 divided by column 2 = 9 years average for all 30 States
3	2	6	
4	5	20	Mean = between 7 & 8 years
5	2	10	
6	3	18	
7	3	21	
8	6	48	
18 or over	8	144	
–	Total 29	Total 267	

THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

56 Old Suncook Road
Concord, New Hampshire 03301-7317

Paula T. Rogers
Commissioner

January 5, 2000

Honorable Jeanne Shaheen
Governor
State of New Hampshire
State House, Room 208
Concord, New Hampshire 03301

&

Honorable Beverly A. Hollingworth
Senate President
State of New Hampshire
State House, Room 302
Concord, New Hampshire 03301

Honorable Donna P. Sytek
Speaker of the House
State of New Hampshire
State House, Room 310
Concord, New Hampshire 03301

RE: REPORT – 1998 Chapter 280 – Dental Anesthesia

Chapter 280 of the 1998 Session is an act requiring insurance coverage for hospitalization and anesthesia for dental procedures for certain patients.

Section 5 of Chapter 280 states that...."The insurance department shall analyze the effect of the coverage requirements contained in this act on the overall cost of health and dental insurance in the group markets. The insurance department shall submit a report on its analysi to the president of the senate, the speaker of the house, and the governor's office by January 1, 2000."

The Insurance Department has not been able to determine that any significant impact has occurred to the cost of health and dental insurance in the group markets since the passage of this legislation.

Sincerely,

Paula T. Rogers
Commissioner

PTR:dol

cc: Monica Ciolf, Deputy Commissioner
David Sky, LAH Actuary
Alex Feldvebel, Health Policy Analyst

(1998C280rpt.doc)

400-A:11-a. Special Advisory Council on Mandated Health Insurance Benefits.

I. There is hereby established a special advisory council on mandated health insurance benefits. The purpose of the special council shall be to advise the governor and the general court on the social and financial impact of current and proposed mandated benefits, in the manner set forth in this article.

II. The council shall consist of sixteen members:

(a) Ten members shall be appointed by the governor with the consent of the executive council, including

(1) one physician,

(2) one chief executive officer of a general acute care hospital,

(3) one allied health professional,

(4) one representative of small business,

(5) one representative of a major industry,

(6) one expert in the field of medical ethics,

(7) two representatives of the accident and health insurance industry, and

(8) two citizen members who shall not also be in one of the categories aforementioned.

(b) Two members shall be appointed by the senate president.

(c) Two members shall be appointed by the speaker of the house of representatives.

(d) The commissioner and the commissioner of the department of health and human services shall serve as nonvoting members.

III. All members shall be appointed for terms of four years each, except that appointments to fill vacancies shall be made for the unexpired terms. No person shall be eligible to serve for or during more than two successive four-year terms; provided, however, that a person appointed to fill a vacancy when less than two years remain in the term may serve two additional four-year terms.

IV. The council shall meet regularly, at least one time each quarter, and at the request of the governor. A majority of the members shall constitute a quorum.

V. The council shall select a chair and a vice chair from among its members.

VI. Members of the special council shall be reimbursed for their necessary expense of travel and subsistence. Said expenses shall be a charge upon available funds and the appropriation of the insurance department.

VII. The insurance department and the department of health and human services shall provide staff assistance to the special council.

400-A:11-b. Duties of the Special Advisory Council on Mandated Health Insurance Benefits.

The special advisory council on mandated health insurance benefits shall,

I. Develop and maintain, with the insurance department, a system and program of data collection to assess the impact of mandated benefits, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers and other data as may be appropriate.

II. Advise and assist the insurance department on matters relating to mandated insurance benefits and provider regulations.

III. Prescribe the format, content, and timing of information to be submitted to it in its evaluation and analysis of proposed and existing mandated benefits and providers. Such format, content, and timing requirements shall be binding upon all parties submitting information to the special council in its assessment of proposed and existing mandated benefits and providers.

IV. Provide evaluations and analyses of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues in accordance with RSA 400-A:11-c.

V. Provide additional information and recommendations, relating to any system of mandated health insurance benefits.

VI. Report annually on its activities to the standing committees of the general court having jurisdiction over insurance by December 1 of each year.

VII. Review and evaluate as necessary the benefits and other provisions of the essential and standard health benefits plans made available in the state, and submit to the insurance department any proposed modifications needed to maintain or enhance the affordability and marketability of the plans.

400-A:11-c. Study of proposed mandated benefits and providers.

I. Except as provided in paragraph II, every bill introduced in the general court containing a mandated health insurance benefit shall be referred by the speaker of the house of representatives or the president of the senate, as the case may be, to the council created in RSA 400-A:11-a. The council shall prepare and forward to the governor, the speaker of the house of representatives, and the president of the senate a study that assesses the social and financial impact and the medical efficacy of the proposed mandate. The council shall submit its assessment within twelve months of receiving the referral from the general court. The general court shall not pass any bill containing a new or increased mandated health insurance benefit until the twelve-month period has passed.

II. Whenever a bill, as described in paragraph I, is identical or substantially similar to a bill previously reviewed by the council within the three-year period immediately preceding the then current session of the general court, the speaker of the house of representatives or the president of the senate, as the case may be, may refer the bill to the council to determine the council's

study needs to be updated or revised. Within thirty days of receiving such a referral, the council shall notify the person who made the referral whether its study needs to updated or revised. If updates or revisions are necessary, the council shall submit its updated or revised assessment within six months of receiving the referral.

III. The council shall also assess the social and financial effects and the medical efficacy of mandated benefits as they exist as of the July 1, 2003. The standing committees of the general court having jurisdiction over health insurance matters shall submit a schedule of evaluations to the council setting forth the dates by which particular mandates shall be evaluated by the council with all such evaluations to be completed by December 1, 2004.

Speakers

SENATE INSURANCE COMMITTEE

Date 05/13/03 Time 8:30 AM Public Hearing on **Bill # HB 316-FN**

relative to insurance coverage for anesthesia for child dental care.

Please check box(es) that apply.

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☐	☑	☐	Rep. Di Frucia	
☑	☑	☐	Wendy Stoops D.M.D	N.H. Dental Society
☑	☑	☐	Douglas W. Johnson, D.M.D	N.H. Dental Soc
☐	☑	☐	James J. Williamson	NH Dental Soc.
☑	☐	☐	Liz Murphy	HIAA and Cigna
☐	☑	☐	ANDRÉ A. MARTEL	CONSTITUENTS/CO SPONSOR
☑	☑	☐	Tim Bianco	NH Dental Society
☐	☐	☑	MAURA WESTON	ANTHEM
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Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: May 15, 2003

THE COMMITTEE ON Insurance

to which was referred House Bill 316-FN

AN ACT relative to insurance coverage for anesthesia for child dental care.

VOTE: 5-0

2003- 1649s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Russell E. Prescott
For the Committee

HB316 Docket

Next|Prev|Results List|Main|Bill Status

Bill Title: relative to insurance coverage for anesthesia for child dental care.

Date	Body	Description
1/9/2003	**H**	Introduced and ref to Commerce; HJ 12, p190
1/21/2003	**H**	Copy to Chairman on 1/21/2003
1/21/2003	**H**	Hearing Jan 29 1:15 RM302,LOB
2/5/2003	**H**	Subcom Work Session Feb 11 9:00 RM302,LOB
2/11/2003	**H**	Subcom Work Session Feb 20 after session RM302,LOB
2/21/2003	**H**	Subcom Work Session Mar 5 3:00 RM302,LOB
3/6/2003	**H**	Subcom Work Session Mar 14 3:00 RM302,LOB
3/19/2003	**H**	Maj Report OTP/AM for Mar 25 (Vote 20-0;CC)
3/19/2003	**H**	Prop Comm Am{0397}; HC26, p691
3/25/2003	**H**	Passed with Am; HJ29-pt 1, p822 + pt 2, p965
4/24/2003	**S**	Introduced and Ref. to Insurance; SJ 14, Pg.342
5/2/2003	**S**	Hearing; May 13, 2003, Room 101, LOB, 8:30 a.m.; SC21
5/16/2003	**S**	Committee Report; Ought to Pass with Amendment{1649},(New Title), [05/22/03]; SC23, Pg.15-17
5/22/2003	**S**	Committee Amendment{1649},(New Title), AA, VV; SJ 17, Pg.450-452
5/22/2003	**S**	Ought to Pass with Amendment{1649},(New Title), MA, VV; OT3rdg; SJ 17, Pg.452
5/22/2003	**S**	Passed by 3rd Reading Resolution; SJ 17, Pg.479
5/29/2003	**H**	House Nonc with Sen Am req Conf Comm, Rep Fraser MA VV; HJ 45, p1446
5/29/2003	**H**	(Spkr appts: Reps Hunt, Fraser, Quandt & Meader)
6/5/2003	**S**	Sen. Flanders Accede to Request for Committee of Conference, MA, VV; SJ 19, Pg.530
6/5/2003	**S**	President Appoints; Senators Flanders, Martel, Cohen; SJ 19, Pg.530
6/9/2003	**H**	Conf Comm Meeting June 12 9:30 RM302,LOB
6/12/2003	**H**	==CANCELLED==Continued Conf Comm Meeting June 17 2:00 RM302,LOB
6/19/2003	**S**	Committee of Conference Report; House Am{2091}, Filed;
6/24/2003	**S**	Conference Committee Report{2091}, Adopted, VV
6/24/2003	**H**	Conf Comm Report Adopted VV;

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Docket Abbreviations