REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR ANESTHESIA/HOSPITALIZATION FOR DENTAL CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 80

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

COMMONWEALTH OF VIRGINIA

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SENATE

January 10, 2000

To: The Honorable James S. Gilmore, III
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) to assess the social and financial impact and the medical efficacy of House Bill 2007, regarding mandatory coverage for anesthesia/hospitalization for dental care.

Respectfully submitted,

Stephen H. Martin
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

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INTRODUCTION

The House Committee on Corporations, Insurance and Banking referred House Bill 931 to the Advisory Commission during the 1998 Session of the General Assembly. The patron of House Bill 931 is Delegate James M. Shuler. The bill was reintroduced as House Bill 2007 in the 1999 Session.

The Advisory Commission held a public hearing on the bill on May 4, 1999, in Richmond. In addition to the patron, one other speaker spoke in support of the bill on behalf of the Virginia Dental Association. Representatives from three organizations, the Virginia Association of Health Plans (VAHP), the Virginia Manufacturers' Association (VMA), and the Health Insurance Association of America (HIAA), spoke in opposition to the bill. Written comments were received in support of the bill from the Virginia Dental Association. The VAHP and the Virginia Manufacturers' Association offered written comments that opposed the bill.

The Advisory Commission concluded its review of House Bill 2007 on June 1, 1999.

SUMMARY OF PROPOSED LEGISLATION

House Bill 2007 amends the accident and sickness chapter of Title 38.2 of the Code of Virginia by adding a section to require any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization (HMO) providing a health care plan for health care services to provide coverage for general anesthesia and hospital charges for dental care provided to a covered person who (i) is under the age of five, or (ii) is severely disabled, or (iii) has a medical condition and requires hospitalization or general anesthesia for dental care treatment. The policy, contract, or plan must also provide coverage for general anesthesia and treatment rendered by a dentist for a medical condition covered under the policy, contract, or plan (Appendix A).

Delegate Shuler submitted amended language to the Advisory Commission on June I, 1999.

The amended bill requires individual and group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, individual or group subscription contracts and HMO plans to provide coverage for medically necessary general anesthesia and hospitalization or facility charges for dental care. The facility must be licensed to provide outpatient surgical

procedures. The covered person must be determined by a licensed dentist in consultation with the person's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to provide dental care safely and effectively. The covered person must also be under the age of five, or severely disabled, or have a medical condition that requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care.

The amended bill provides that the determination of medical necessity must include consideration of whether the age, physical, or mental condition of the person requires the utilization of general anesthesia as the bill provides.

The insurer, corporation, or HMO may require prior authorization in the same manner as required for other benefits. The coverage can be restricted to health care providers licensed to provide anesthesia, and facilities charges can be restricted to facilities licensed to provide surgical services.

The amended bill does not require coverage for dental care that is incident to the section. The bill does not apply to short-term travel, accident-only, limited or specified disease policies, or Medicare supplement contracts or similar coverage under state or federal government plans. The amended bill would apply to policies, contracts, or plans delivered, issued for delivery, or renewed in Virginia on or after July 1, 2000.

SOCIAL IMPACT

The American Academy of Pediatric Dentistry (AAPD) published a statement in 1995 entitled "Rationale and Justification for Medical Plan Reimbursement of Hospital Costs Associated with General Anesthesia When Provided in the Course of Dental Treatment for Young and Special Needs Patients," which reported that most dental care is safely provided in an office setting utilizing local anesthesia. However, there is a group of patients for whom routine approaches are either inappropriate or ineffective. This group includes infants and children who cannot comprehend the need for their treatment, and patients with special needs who cannot cope with invasive, potentially uncomfortable, and psychologically threatening procedures. These individuals may possess physical, medical, or intellectual limitations and developmental disabilities preventing a dentist from meeting their dental needs by using a traditional office approach.

The AAPD notes that for this population group, it is increasingly considered outside the parameters of acceptable medical care to impose physical restraints and to force medical treatment procedures upon an unwilling and acutely anxious patient when other modalities, such as general anesthesia, exist. In addition, combating the movements of an unwilling patient compromises the ability of the dentist to provide an acceptable level of diagnostic, therapeutic, surgical, restorative, and preventive dental care.

A representative of the Virginia Dental Association stated that safety is a major problem with sedatives in the dentist's office because disabled and special children may not react to sedatives well, restraints may be required, or the patient and staff may become injured if the patient is agitated. The dentist further noted that even when adequately sedated, local anesthetic would still be required. When treating very young children, the amount of local anesthetic used must be carefully monitored because dosages are based on weight, and an overdose can occur. Extensive treatment could require multiple appointments because the dentist would be limited in the amount of local anesthetic he could administer.

The ADA and the AAPD define "medically necessary care" as "the reasonable and appropriate diagnosis, treatment and follow-up care (including supplies, appliance and devices) as determined by qualified, appropriate health care providers in treating any condition, illness, disease, injury, or birth development malformations." The ADA and the AAPD state that care is medically necessary for the purpose of controlling or eliminating infection, pain, and disease and restoring facial disfiguration or function necessary for swallowing or chewing. Proponents argue that treatment that meets the above criteria should not trigger the exclusion of medical insurance benefits payable for general anesthesia regardless of whether it is a medical or dental treatment. The AAPD's survey found that when general anesthesia was indicated and denied, comparable treatment results could be achieved in less than half the cases. Patients either received compromised outcomes or were denied treatment altogether in 60% of these cases.

Although some patients are able to access medical benefits for anesthesia and hospitalization for dental treatment, proponents indicated that for most patients, these benefits are not available. Respondents to the AAPD's survey indicated the majority of the respondents believed that less than 50% of their patients could obtain these benefits under their health insurance plans. These figures include all types of cases and justifications for care under general anesthesia.

FINANCIAL IMPACT

Lack of reimbursement can present a financial burden to the families of these patients and may force compromises in care or the denial of needed services and subsequent harm to the patient. In the AAPD's survey of its members, practitioners indicated that parents responded that the costs associated with hospital care and general anesthesia were cited as the most common factor influencing parental decisions. One dentist estimated a cost per claim is $2,150, while an orthodontic treatment is $3,500 per patient.

Proponents argue that denial of medical benefits effectively eliminates the option of general anesthesia for most families. The financial burden experienced by the families of persons with disabilities is also a concern of proponents. These

families already experience economic consequences from the day-to-day care of a family member with special needs. The AAPD contends that even those families that can afford the cost of such care should not be unfairly denied benefits for which they should be entitled by the payments of their premiums. If the financial barriers were removed, 83% of the dentists responding to the AAPD's survey estimated that parental acceptance of general anesthesia would increase.

MEDICAL EFFICACY

The AAPD notes that dentists have developed a variety of techniques to effectively address the challenges associated with these patients. One of the most effective techniques is to perform dental care under general anesthesia, either in a hospital, surgicenter, or properly equipped dental office. Hospital-based dental care under general anesthesia is an integral part of the curriculum of all accredited pediatric dental training programs and is recognized as legitimate justification for hospital admission. General anesthesia is provided because of the patient's inability to receive, tolerate, or cooperate with needed treatment because of such factors as age, disability or impairment and not because of the nature of the treatment itself.

The AAPD contends that general anesthesia is the accepted standard of care for this population group and that there are no comparable alternatives to general anesthesia for this group. The AAPD further contends that the distinction insurers make between medical care and dental care for this population is arbitrary.

Children qualifying for dental care under state Medicaid programs have, under federal program mandates, direct access to dental care under general anesthesia when criteria for such care are met. The American Dental Association, the AAPD, the American Medical Association, the U.S. Department of Health and Human Services, and most other professional dental and medical organizations support dental care under general anesthesia in specific instances.

The AAPD surveyed its members in 1995 regarding access to hospitalization and the use of general anesthesia for children and special needs patients. Eighty-four percent of the respondents reported providing dental care under general anesthesia as part of their practices. Ninety-three percent indicated that general anesthesia is provided in a hospital or outpatient surgery center, while only six percent reported providing care under general anesthesia in the dental office. Respondents to the AAPD's survey indicated that the number of patients treated under general anesthesia is not large when compared to the number of patients seen in a pediatric dental practice. Practitioners participating in the study indicated that the average number of patients treated annually under general anesthesia was 49, representing only 1% of pediatric dental patients in practices utilizing general anesthesia. Of patients receiving this treatment, 42% were Medicaid-funded and 58% were covered by private insurance.

Pediatric dentists participating in the AAPD's survey indicated that alternative treatment strategies are not available to provide routinely successful outcomes. Conscious sedation or other approaches to treatment provided comparable results only 40% of the time. Practitioners estimated that utilization of other approaches that accomplished treatment, but with an acknowledged compromised result, occurred 34% of the time. Deferral of treatment or the complete lack of treatment occurred 31% of the time.

Opponents of the bill commented that children often experience additional complications from anesthesia, sometimes including death. They were concerned that the original bill language required changes to ensure that the dental anesthesia and hospitalization was medically necessary. They also believe that anesthesia should be administered by a professional certified to do so.

CURRENT INDUSTRY COVERAGE

The State Corporation Commission's Bureau of Insurance surveyed fifty of the top writers of accident and sickness insurance in Virginia regarding House Bill 2007. Of the twenty-one respondents that completed the survey, seven indicated that they currently provide the coverage required in the original bill. One carrier reviews these claims on a case-by-case basis. Fourteen respondents to the survey estimated that the cost to provide coverage for anesthesia and hospitalization for dental procedures would be between $0.01 and $3.00 per month per standard group certificate. Seven insurers provided cost figures between $0.01 and $1.50 per month per standard individual policy.

Proponents of the bill argue that coverage for the use of general anesthesia and hospitalization for dental procedures is inconsistent. The lack of common standards, common definitions, and common enforcement make it difficult for most consumers to know if such benefits are covered under their policies. The AAPD states that the exclusion of hospital-related benefits, when dental care is provided, is usually poorly understood at the time of contract purchase by both the purchaser and the plan beneficiary.

Respondents to the AAPD's survey indicated that they believe that the system of medical insurance denials is uneven. Only forty percent of the responding practitioners felt that coverage determinations were uniform throughout the medical benefits industry.

COVERAGE IN OTHER STATES

According to information provided by the National Insurance Law Service, eight states mandate coverage for general anesthesia and hospital charges for

dental care. The Minnesota and Wisconsin statutes are identical to the language proposed in House Bill 931. Both statutes apply to children under the age of five, individuals with severe disabilities, and individuals with a medical condition that requires hospitalization or general anesthesia for dental care, regardless of the age of the insured. The Louisiana and Oklahoma statutes require coverage for children eight years or younger and individuals with severe disabilities, and individuals with a medical condition that requires hospitalization or general anesthesia for dental care, regardless of the age of the insured. Colorado, Florida, and Tennessee have statutes that require coverage for children as defined by each state but do not apply to adults.

The Alabama Society of Pediatric Dentistry (ASPD) completed a study in March 1998 regarding the impact of hospital dentistry legislation on insurance claims. The study found that to guarantee coverage for dental procedures performed in a hospital setting, annual premium costs per Alabama family would increase $0.97. The ASPD estimated that the cost per claim would be $2,150.

REVIEW CRITERIA

SOCIAL IMPACT

a. *The extent to which the treatment or service is generally utilized by a significant portion of the population.*

Proponents cite the results of an American Academy of Pediatric Dentistry (AAPD) survey of its members in 1995. According to the survey results, approximately 1% of pediatric dental patients were treated with general anesthesia. This figure is for practices that use general anesthesia. Reimbursement for those patients was by Medicaid in 42% of the cases. The remainder (58%) was private payment(s). Proponents also cited the report of the Mississippi Dental Association in connection with similar legislation. Mississippi's coverage would include an estimated 300 children. Based on the Mississippi model, the Virginia legislation would affect 1,000 eligible children.

b. *The extent to which insurance coverage for the treatment or service is already available.*

In a 1999 survey by the Bureau of Insurance of the top 50 accident and sickness insurance companies in Virginia, twenty-one insurers currently writing applicable business responded. Seven (33%) of the twenty-one companies reported that they currently provide the coverage required by House Bill 2007. Thirteen of the respondents do not provide the coverage, and one company provides coverage on a case-by-case basis.

Proponents of the legislation report coverage by some insurers but some that do not provide coverage. Some insurers will pay when claim denials are appealed. The AAPD, based on its national survey, estimates that less than 25% of patients are able to obtain coverage, including those who are covered after appeals.

c. *If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.*

According to the Virginia Dental Association in a survey of Virginia pediatric dentists in 1997, 25% of the patients did not have dental work done or paid out of pocket when general anesthesia was required. Public testimony indicated that the consequences of not treating decayed teeth can include abscesses, infection, pain, fever, and for children, improper development of permanent teeth.

d. *If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.*

Proponents supplied one estimate of $2,150 for each claim. That amount would then be an out-of-pocket expense each time hospitalization or general anesthesia was needed for a dental procedure, if there is no insurance coverage.

e. *The level of public demand for the treatment or service.*

The need for the treatment or service has been estimated at 1% of pediatric dental patients based on the results of the AAPD 1995 survey.

f. *The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.*

Proponents believe that the level of public demand for the coverage is indicated by the number of times coverage is requested and denied. They cite 11% of patients going without treatment because the dental care was not covered by the patients' insurance. The VDA reports a high demand from providers.

g. *The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.*

The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts is not known.

h. *Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

No information or findings of the state health planning agency or the appropriate health system agency regarding the social impact of the mandated benefit was presented during this review. Coverage is provided for these services by Medicaid.

FINANCIAL IMPACT

a. *The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.*

The VDA believes that the proposed coverage would not impact the cost of treatment.

b. *The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.*

The appropriate use of the treatment would be expected to increase to reflect those receiving care who previously abandoned treatment completely because there was no insurance coverage. The inappropriate use of the treatment is not expected to increase.

c. *The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

Proponents believe that the coverage may negate the need for costlier treatment when care is delayed.

d. *The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.*

Proponents of the legislation do not believe that the number and types of providers will be significantly affected. The number of individuals using the coverage is not expected to be great.

e. *The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.*

An increase is anticipated in the administrative expenses of insurance companies, and the premiums and administrative expenses for policyholders because of the expenses associated with such things as policy redesign, form filing, claims processing systems, and marketing. Fourteen insurers providing group coverage in Virginia estimated that the monthly premiums would increase from $0.01 to $3.00. One insurer estimated $3.00 a month. Seven insurers estimated that individual coverage would increase from $0.01 to $1.50 per month.

f. *The impact of coverage on the total cost of health care.*

The overall cost of health care is not expected to significantly increase.

MEDICAL EFFICACY

a. *The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.*

Proponents believe that this coverage makes a significant contribution to patient care because of the role of oral health in total body health. They make the case that a child or disabled individual with untreated dental disease may be unable to receive proper nutrition because of the inability to eat or chew. They believe that lack of dental treatment may affect a person's mental and physical development.

The Virginia Association of Health Plans raised concerns about the quality of care provided because of the mandate. They believe that the procedure should be performed in a licensed and regulated facility and that anesthesia should be administered by an anesthesiologist. The VAHP representative noted that young children can face more complications from the procedure than adults and that some children have even died as a result.

b. *If the legislation seeks to mandate coverage of an additional class of practitioners:*

1) *The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.*

Not applicable.

2) *The methods of the appropriate professional organization that assure clinical proficiency.*

Not applicable.

EFFECTS OF BALANCING THE SOCIAL, FINANCIAL, AND MEDICAL EFFICACY CONSIDERATIONS

a. *The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.*

Proponents believe the benefit addresses a medical need because the dental care is necessary. Proponents believe that the bill addresses required care for those with special needs.

The representative of the Virginia Association of Health Plans believes that this bill blurs the distinction between medical coverage and dental coverage. The representative of the Virginia Manufacturers Association noted that dental coverage is not a part of every health insurance policy. They believe that dental coverage should be treated like other excluded services.

b. *The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.*

Proponents believe that the cost of the mandate is not significant when compared to the benefit. Opponents of the mandate pointed to the overall effect of mandated benefits on premiums and the number of uninsured Virginians.

c. *The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.*

The cost of a mandated offer of coverage is anticipated to be higher because the cost would rest on only those who select the coverage. In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual.

RECOMMENDATION

The Advisory Commission unanimously voted to recommend that House Bill 2007 be enacted as amended by the bill's patron on June 1, 1999. The amended language limits coverage to medically necessary anesthesia provided in a hospital or outpatient surgery facility. The facility must be licensed to provide outpatient surgical procedures. The dentist is to consult with the covered person's treating physician. The coverage is limited to expenses for health care providers licensed to provide anesthesia services and facilities licensed to provide surgical services. Prior authorization may be required, as is required for other covered benefits. The bill does not require coverage for dental care incident to the section.

CONCLUSION

The Advisory Commission believes that the proposed mandate will be beneficial and will not significantly increase the cost of insurance. The amendments proposed by the patron of the bill address many of the concerns raised by those who opposed the proposal.

APPENDIX A

994650450

HOUSE BILL NO. 2007

Offered January 19, 1999

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.8, relating to accident and sickness insurance; coverage for hospitalization and anesthesia for dental procedures.

Patron—Shuler

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.8 as follows:

§ 38.2-3418.8. Coverage for hospitalization and anesthesia for dental procedures.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for general anesthesia and hospital charges for dental care provided to a covered person who (i) is under the age of five, (ii) is severely disabled or (iii) has a medical condition and requires hospitalization or general anesthesia for dental care treatment. Such policy, contract or plan shall also provide coverage for general anesthesia and treatment rendered by a dentist for a medical condition covered under such policy, contract or plan.

B. The provisions of this section are applicable to any policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999.

C. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.7~~ *38.2-3418.8*, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 58 (§ 38.2-5800 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

Amendment in the
Nature of a Substitute

HOUSE BILL NO. 2007

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.8, relating to accident and sickness insurance; coverage for hospitalization and anesthesia for dental procedures.

Be it enacted by the General Assembly of Virginia:

1. That §38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.8 as follows:

§38.2-3418.8. Coverage for hospitalization and anesthesia for dental procedures.

A. Notwithstanding the provisions of §38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for medically necessary general anesthesia and ~~hospital~~ hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a covered person who is determined by a licensed dentist in consultation with the covered person's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care and (i) is under the age of five, or (ii) is severely disabled or (iii) has a medical condition and requires ~~hospitalization or~~ admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment. ~~Such policy, contract or plan shall also provide coverage for general anesthesia and treatment rendered by a dentist for a medical condition covered under such policy, contract or plan.~~ For purposes of this section, a determination of medical necessity shall include but not be limited to a consideration of whether the age, physical or mental condition of the covered person

requires the utilization of general anesthesia and the admission to a hospital or outpatient surgery facility to effectively and safely provide the underlying dental care.

B. Such insurer, corporation or health maintenance organization may require prior authorization for general anesthesia and hospitalization or surgical facility charges for dental procedures in the same manner that prior authorization is required for other covered benefits.

C. Such insurer, corporation or health maintenance organization shall restrict coverage for general anesthesia expenses to those health care providers who are licensed to provide anesthesia services and shall restrict coverage for facility charges to facilities licensed to provide surgical services.

D. The provisions of this section shall not be construed to require coverage for dental care incident to the coverage provided in this section.

~~B.~~E. The provisions of this section are applicable to any policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, ~~1999~~2000.

~~C.~~F. The provisions of this section shall not apply to short-term travel, accident-only, limited for specified disease policies, ~~or to short-term nonrenewable policies of not more than six months' duration~~ or contracts designed for issuance to persons eligible for coverage under Title XVII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

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