challenged the statute, arguing primarily that it is preempted by section 514(a) of the federal Employee Retirement Income Security Act (ERISA), which provides that ERISA "shall sup­ ercede any and all State laws insofar as they...relate to any employee benefit plan." 29 U.S.C. § 1144(a).

Texas officials defended the liability provision, arguing that it is targeted not at an "ERISA plan" established by an employer to provide benefits to an employee, but at health plans established by health insurance companies as a vehicle for bearing the risks of health insurance and providing coverage to an ERISA plan for those employees. Thus, Texas argued that the defendant insurance companies are operating health plans but not ERISA plans. The court agreed, stating that the "health plans provided by health insurance carriers, health maintenance organizations, or managed care entities...and the health care entities themselves, cannot constitute ERISA plans" because they are not established by or maintained by an employer. "Rather, plaintiffs are medical service providers to ERISA plans and their members." The court also rejected plaintiffs' other arguments that the liability provision "relates to," "refers to," and "is connected with" ERISA plans—finding essentially that the statute applies to managed care entities' treatment decisions "regardless of whether the commercial coverage or membership therein is ultimately secured by a ERISA plan." The court concluded that ERISA does not preempt a state law claim challenging the quality of a benefit (because ERISA "simply says nothing about the quality of benefits received"), such that "the Act does not constitute an improper imposition of state law liability on the enumerated entities." However, a state law claim based on a failure to treat, where the failure is the result of a determination that the requested treatment was not covered by the plan, is preempted by ERISA.

However, Judge Gilmore struck down the Act's independent review organization (IRO) provision and other provisions "that address specific responsibilities of an HMO and further explain and define the procedure for independent review of an adverse benefit determination by an IRO." Plaintiffs argued that these provisions are preempted by ERISA because they "mandate employee benefit structures or their administration," citing New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995). On this claim, the court agreed with plaintiffs, finding that such provisions are connected with ERISA plans and are precisely the kind of state-based procedures that Congress intended to preempt when it enacted ERISA.

Board of Dental Examiners

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COMDA—Executive Officer: Karen R. Wyant ♦ (916) 263-2595 ♦ Internet: www.comda.ca.gov/

The Board of Dental Examiners (BDE) is a consumer protection agency within the state Department of Consumer Affairs (DCA). BDE is charged with enforcing the Dental Practice Act, Business and Professions Code section 1600 et seq. The Board's regulations are located in Division 10, Title 16 of the California Code of Regulations (CCR).

BDE licenses dentists (DDS/DMD) and all categories of licensed dental auxiliaries, including registered dental assistants (RDA), registered dental assistants in extended functions (RDAEF), registered dental hygienists (RDH), registered dental hygienists in extended functions (RDHEF), and registered dental hygienists in alternative practice (RDHAP).

The Board is authorized to establish standards for its approval of dental schools and dental auxiliary training programs; prescribe the subjects in which its licensees should be examined; license applicants who successfully pass the examinations required by the Board; set standards for dental practice; and enforce those standards by taking disciplinary action against licensees as appropriate. BDE is also responsible for registering dental practices (including mobile dental clinics) and corporations; establishing guidelines for continuing education requirements for dentists and dental auxiliaries; issuing special permits to qualified dentists to administer general anesthesia or conscious sedation in their offices; approving radiation safety courses; and administering the Diversion Program for substance-abusing dentists and dental auxiliaries.

The Board consists of fourteen members: eight practicing dentists, one RDH, one RDA, and four public members. The Governor appoints twelve of the Board's fourteen members; the Senate Rules Committee and the Assembly Speaker each appoint one public member.

BDE's Committee on Dental Auxiliaries (COMDA) was created by the legislature "to permit the full utilization of dental auxiliaries in order to meet the dental care needs of all the state's citizens." COMDA is part of BDE, and assists the Board in regulating dental auxiliaries. Under Business and Professions Code section 1740 et seq., COMDA has specified functions relating to the Board's approval of dental auxiliary education programs, licensing examinations for the various categories of auxiliaries, and applicants for auxiliary licensure. Additionally, COMDA advises the BDE as to needed regulatory changes related to auxiliaries and the appropriate standards of conduct for auxiliaries. COMDA is a separate nine-member panel consisting of three RDHs (at least one of whom is actually employed in a private dental office), three RDAs, one BDE public member, one licensed dentist who is a member of the Board's Examining Committee, and one licensed dentist who is neither a Board nor Examining Committee member.
Major Projects

Minimum Infection Control Standards

On December 4, BDE published notice of its intent to amend section 1005, Title 16 of the CCR, which sets forth its minimum standards for infection control to prevent the transmission of bloodborne pathogens in the dental care setting. Existing law requires BDE to review its infection control regulations annually; during its most recent review, BDE learned that California dental offices may only use disinfectants which are registered with the California Environmental Protection Agency (Cal-EPA); thus, the Board proposes to amend section 1005 to require that dental offices use only disinfectants approved by Cal-EPA.

Existing section 1005 requires all critical and semi-critical instruments to be packaged before sterilization if they are not to be used immediately. During its most recent review of this provision, the Board determined that this regulation should be modified to require that all critical and semi-critical instruments be packaged, sterilized, and should remain sealed until used.

At this writing, the Board is scheduled to hold a public hearing on these proposed amendments at its January 22 meeting.

Clinical Periodontics Examination

On December 4, BDE published notice of its intent to amend section 1032.4, Title 16 of the CCR, which describes the clinical periodontics examination for dentists. The regulation currently requires dental applicants to use hand instruments for scaling during the examination, and prohibits them from using ultrasonic or other mechanical scaling devices. The Board seeks to amend section 1032.4 to make it consistent with section 1082.1, the RDH examination regulation (see below); as amended, ultrasonic, sonic, handpiece-drive, or other mechanical scaling devices may be used for scaling during the clinical periodontics examination at the discretion of the Board.

The Board has scheduled no public hearing on this proposal; at this writing, it is accepting written comments until January 18.

Continuing Education Requirements

On December 4, BDE published notice of its intent to amend section 1017, Title 16 of the CCR, which sets forth the Board’s continuing education (CE) requirements for BDE licensees. The Board proposes to amend section 1017(b)(1) to repeal a provision requiring dentists who intend to sponsor, utilize, or employ dental auxiliaries licensed in extended functions to complete at least seven units in the management, supervision, and utilization of such auxiliaries; this amendment conforms the Board’s regulations to SB 2239 (Committee on Business and Professions) (Chapter 878, Statutes of 1998) (see LEGISLATION).

The Board’s laws and regulations do not currently require RDAEFs, RDHEFs, or RDHAPs to complete continuing education courses. The Board also seeks to amend section 1017 to require licensees in these categories to complete 25 units of approved CE during each two-year license renewal period.

At this writing, the Board plans to hold a public hearing on its proposed amendments to section 1017 at its January 22 meeting.

Electronic CE Courses

On September 18, BDE published notice of its intent to amend section 1017, Title 16 of the CCR, to expressly authorize full CE credit for Board-approved interactive instruction courses via computers, telephone conferencing, video conferencing, or other electronic mediums. The Board held no public hearing on this proposal, but accepted written comments until November 2. Having received no comments, BDE approved the proposed amendments as published at its November 6 meeting; at this writing, the rulemaking file on the proposed amendment is pending at the Office of Administrative Law (OAL).

Clinical Examination Requirements for Dentists and Auxiliaries

On September 18, BDE published notice of its intent to amend sections 1033.1, 1080.1, 1081.2, and 1082.2, Title 16 of the CCR. These sections set forth the Board’s clinical examination requirements for dentists (section 1033.1), dental auxiliaries (section 1080.1), RDAEFs (section 1081.2), and RDHEFs (section 1082.2). These regulations currently require examinees to furnish patients, instruments, engines, and materials necessary for the clinical examination. However, the regulations are not consistent regarding patient acceptability. The Board’s proposed amendments would make consistent patient acceptability standards for dental and dental auxiliary examinations, incorporate current guidelines into regulations for the RDAEF and RDHEF examinations, and eliminate redundant language. The Board held no public hearing on this proposal, but accepted written comments until November 2. Having received no comments, BDE approved the proposed amendments as published at its November 6 meeting; at this writing, the rulemaking file on the proposed amendment is pending at OAL.

On August 7, BDE published notice of its intent to amend sections 1081.2 and 1082.2, Title 16 of the CCR, to reduce the time period allowed for RDAEF and RDHEF applicants to complete the endodontic portion of the licensure examination from two and one-half hours to one and one-half hours. The Board held no public hearing on this proposal, but accepted written comments until September 21. Having received no comments, BDE approved the proposed amendments as published at its November 6 meeting; at this writing, staff is preparing the rulemaking file for submission to OAL.

Acceptability of “Dental Practice Administration” Courses for CE Credit

On September 18, BDE published notice of its intent to amend section 1016(a), Title 16 of the CCR, which currently requires the Board to approve CE courses which provide a
learning experience in the area of dental and medical health, preventive dental services, diagnosis and treatment planning, clinical procedures, basic health sciences, dental practice administration, or the Dental Practice Act and other laws specifically related to dental practice and which are designed to directly enhance the licentiate’s knowledge, skill, or competence in the provision of service to patients or the community. The regulation further spells out numerous types of courses which qualify as “dental practice administration” courses.

BDE decided to amend section 1016(a) to delete “dental practice administration” as an acceptable course of study whereby a dental licentiate may receive CE credit. According to its statement of reasons, the Board has monitored advertisements of various CE providers, and the ads promote courses that do not comply with BDE’s CE regulations. Additionally, BDE continually receives biennial reports listing courses in dental administration which focus on areas outside the scope of the CE program. In spite of its efforts to spell out the acceptable parameters for courses in dental practice administration, the Board continues to see “blatant abuses.” Therefore, BDE sought to delete “dental practice administration” as the subject of approved CE courses. BDE sought public comments on its proposal by November 2.

At a hearing on its proposal on November 6, the Board announced that it had received so much written testimony in opposition to the proposed amendment that it had decided to table the rulemaking indefinitely and hold an informational hearing on the issue at a future date.

RDH Clinical Examination Requirements

On September 18, BDE published notice of its intent to amend section 1082.1, Title 16 of the CCR, which currently requires applicants taking the RDH clinical examination to complete the scaling of one or two quadrants and root planing. Scaling and root planing includes, but is not limited to, complete removal of calculus, soft deposits, and plaque, and smoothing of the unattached tooth surfaces. Section 1082.1 also specifies that no ultrasonic, handpiece-drive or other mechanical scaling device may be used. BDE proposes to amend section 1082.1 to permit RDH candidates, at the Board’s discretion, to use ultrasonic, handpiece-drive or other mechanical scaling devices to complete the scaling and root planing procedure during the examination.

BDE held no public hearing on this proposal, but accepted written comments until November 2. As no comments were received, BDE approved the proposed amendment as published at its November 6 meeting; at this writing, the rulemaking file on the proposed amendment is pending at OAL.

RDHAP Program Regulations

Effective January 1, 1998, AB 560 (Peralta) (Chapter 753, Statutes of 1997) created a new category of licensure: the registered dental hygienist in alternative practice (RDHAP). The passage of AB 560 follows years of effort by the California Dental Hygienists’ Association to create the RDHAP category. [13:2&3 CRLR 64]

Under Business and Professions Code section 1768 et seq., licensed RDHs who have been engaged in clinical practice as a dental hygienist for a minimum of 2,000 hours during the immediately preceding 36 months, possess a bachelor’s degree or its equivalent, complete 150 hours of BDE-approved coursework, and pass a written examination prescribed by the Board may be issued an RDHAP license. Once licensed, an RDHAP may practice as an employee of a dentist or of another RDHAP, as an independent contractor, or as a sole proprietor of an alternative dental hygiene practice. An RDHAP may perform duties to be established by BDE in the following settings: residences of the homebound, schools, residential facilities and other institutions, and dental health professional shortage areas as certified by the Office of Statewide Health Planning and Development. An RDHAP may only perform services for a patient who presents a written prescription for dental hygiene services issued by a licensed dentist or physician who has performed a physical examination and rendered a diagnosis of the patient prior to providing a prescription; the prescription is valid for no more than 15 months from the date it was issued.

AB 560 requires BDE to adopt several sets of regulations to implement it by January 1, 1999. Specifically, the Board must adopt regulations defining the duties which a licensed RDHAP may perform, and the contents of the 150 hours of coursework that must be successfully completed for licensure. COMDA worked on the contents of the regulations throughout 1998, and presented them to the Board at its May 1998 meeting.

On June 19, the Board published notice of its intent to adopt the regulations recommended by COMDA—new sections 1073.2, 1073.3, 1079.2, 1079.3, 1090, and 1090.1, Title 16 of the CCR; BDE held a public hearing on the regulations at its August 14 meeting.

New section 1073.2 would set forth general requirements for the Board’s approval of RDHAP educational programs, and new section 1073.3 would set forth specific requirements which must be met by an RDHAP educational program in order to be approved by the Board. New section 1079.2 would specify application requirements for those seeking licensure as an RDHAP, and new section 1079.3 would set forth the examination requirements for RDHAP licensure.

New section 1090 would set forth the duties and settings in which an RDHAP may perform. The section states that “independently and without the supervision of a licensed dentist,” an RDHAP may, upon the prescription of a California-licensed dentist or physician, perform the duties assigned to a registered dental hygienist by section 1088(c), Title 16 of the CCR. These duties include root planing, polish and contour restorations, oral exfoliative cytology, application of pit and fissure sealants, and specified functions relating to the
preliminary examination of a patient. Section 1090 also sets forth procedures that an RDHAP may not undertake; these include diagnosing and treatment planning; surgical or cutting procedures on hard or soft tissue; fitting and adjusting of correctional and prosthodontic appliances; prescribing medication; placing, condensing, carving, or removing permanent restorations, including final cementation procedures; and administering local or general anesthesia or oral or parenteral conscious sedation. Finally, section 1090 specifies the required contents of the written prescription from the dentist or physician to the RDHAP.

New section 1090.1 would require an RDHAP, prior to establishing an independent practice, to provide to BDE documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services, on a form specified by the Board.

Following the August hearing, the Board adopted the proposed regulations as recommended by COMDA. At this writing, staff is preparing the rulemaking record on these regulations for submission to OAL.

Clinical Cast Restoration and Amalgam

In June 1998, BDE published notice of its intent to amend section 1032.5, Title 16 of the CCR, which describes the cast restoration and amalgam portion of the clinical dental examination. Under the rule, an examinee must satisfactorily complete one Class 2 amalgam restoration on a tooth that does not have an existing restoration. The Board’s amendment allows dental licensure candidates to select a tooth with an existing restoration. According to the Board, this proposal eases the examination process by increasing the pool of patients, while still accomplishing the requirements of a good, valid, relevant, and reliable test. Following a 45-day comment period, the Board adopted the amendment at its August meeting; OAL approved it on December 1, and it became effective on December 31.

Diversion Program for Substance-Abusing Licensees

Business and Professions Code section 1695 et seq. establishes BDE’s Diversion Program, “a voluntary alternative approach to traditional disciplinary actions,” whose goal is “to identify and rehabilitate licentiates whose competency may be impaired due to abuse of dangerous drugs or alcohol, so that licentiates so afflicted may be treated and returned to the practice of dentistry in a manner that will not endanger the public health and safety.”

SB 1479 (Lewis) (Chapter 257, Statutes of 1996) amended Business and Professions Code section 1695.5 by setting forth the methods by which a person may participate in the Board’s Diversion Program, and specifying that neither acceptance nor participation in the Program precludes the Board from investigating and disciplining a participant for unprofessional conduct. However, SB 1479 requires the Board to close an investigation without further action if (1) the reason for the investigation is “based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol...or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public,” and (2) the complained-of licentiate is accepted into BDE’s Diversion Program and successfully completes it. If the licentiate withdraws or is terminated from the Program by one of the Board’s Diversion Evaluation Committees (DEC), the Board may reopen the investigation and impose disciplinary action. The bill also requires Diversion Program participants to sign an agreement of understanding that their withdrawal or termination from the Program “at a time when a DEC determines the licentiate presents a threat to the public’s health and safety shall result in the Board’s use of the participant’s Diversion Program treatment records in disciplinary or criminal proceedings.”

In December 1997, BDE published notice of its intent to amend sections 1020.1, 1020.2, 1020.4, 1020.6, 1020.7, and 1020.8, Title 16 of the CCR, several of its Diversion Program regulations, to implement SB 1479, define current practices, and remove redundant language. Following a public hearing in January 1998, the Board adopted these regulatory changes; OAL approved them on September 10 and they became effective on October 10.

The Board’s amendment to section 1020.1, which sets forth criteria for admission into the Program, repeals subsection (i), which formerly stated that an applicant who has had his/her license previously disciplined by the Board for substance abuse would be denied admission into the Program. Amended section 1020.2 states the causes for denial of admission into the Program: (a) the applicant does not meet the requirements in section 1020.1, or (b) a DEC determines that the applicant will not substantially benefit from participation in the Program or that the applicant’s participation in the Program creates too great a risk to the public health, safety, or welfare. Amended section 1020.4 clarifies that members of the Board’s DECs are appointed by the Board for four-year terms, and restricts any Committee member to two terms. Amended section 1020.6 states that a DEC may utilize one or more chemical dependency treatment service providers or licensed physicians or psychologists who are competent in their field or specialty, and who have demonstrated expertise in the diagnosis and treatment of substance abuse. The amendments to section 1020.7 specify that a DEC consultant or the Diversion Program manager shall interview an applicant for participation and initiate such clinical assessment as may be necessary to determine applicant eligibility to participate in the Program; the consultant and the program manager make recommendations to a DEC, which makes the final decision as to admission. BDE repealed former section 1020.8, pertaining to confidentiality of Diversion Program records, as that language is now in statute.

RDA Work Experience Requirement

BDE’s amendments to sections 1067 and 1077, Title 16 of the CCR, became effective July 11. To be licensed as an RDA, an applicant must either graduate from a Board-approved educational program in dental assisting or submit
evidence of satisfactory work experience of more than eighteen months as a dental assistant. The Board amended sections 1067 and 1077 to clarify the method used to calculate satisfactory work experience, require the experience to be gained under dentist(s) licensed in California, and specify that the employing dentist(s) must certify that the experience gained involves the performance of duties defined in sections 1085(b) and/or 1085(c), Title 16 of the CCR.

BDE Rejects COMDA's Recommendation to Eliminate RDA Practical Exam

At its November 6 meeting, the Board voted to reject COMDA's recommendation that the RDA practical exam be eliminated, in favor of creating a more comprehensive written exam.

In addition to the educational coursework or eighteen-month work experience noted above, RDA licensure requires passage of both a written and a practical, "hands-on" examination. COMDA believes that some of the procedures tested on the practical exam are not critical or relevant to RDA practice; it is also concerned about the grading of the exam (which, by nature, is subjective) and the exam's construction. In light of its concerns about the validity of the test, COMDA is also unsure as to whether the exam is necessary, and is concerned about the cost of taking the exam for applicants (in terms of time, money, and delayed entrance into the profession).

In 1998, the Board's Examination Committee held an informational hearing on COMDA's proposal, and referred the matter to a task force, charging it with evaluating all alternatives proposed by COMDA. The task force reported to the Board at its November meeting, recommending that the Board retain the RDA practical exam upon several conditions: (1) BDE should direct COMDA to revise the exam to include the testing of the fabrication and placement of a temporary crown on either a typodont or a plaster model; (2) BDE should seek legislation requiring only twelve months of work experience for RDA licensure, rather than the current eighteen months; (3) BDE should require that examination applicants qualifying by work experience first complete Board-approved courses in radiation safety and coronal polishing; and (4) BDE should continue to require separate certification of RDAs who wish to perform ultrasonic scaling. The Board adopted the task force's recommendation.

1997–98 Enforcement Statistics and Issues

At its August meeting, the Board reviewed its enforcement statistics for fiscal year 1997–98, which ended on June 30, 1998. During that year, the Board received 3,172 complaints, opened 631 investigations, referred 108 investigated cases to the Attorney General's Office for the filing of formal charges, and filed 72 accusations. The Board took a total of 93 disciplinary actions, including 17 revocations, 7 voluntary surrenders, 24 probations with suspension, 38 probation,
retraction. Representing CAOMS, attorney Kimberly Dav- enport argued that BDE is the agency rightfully charged with licensing and regulating dentists; thus, any request for clarifica­tion of this issue should come from BDE, not MBC. “If MBC has doubt regarding whether a particular procedure is inside or outside the legitimate scope of another license or certificate, it must refer that question to the Board charged by the Legislature with addressing that issue.” Davenport also disagreed with DCA’s legal analysis, and the fact that the advisory opinion was issued without holding public hearings or hearing public comment “from the very licensiates whose practices may be adversely impacted, should this opinion be utilized against them” (see agency report on MEDICAL BOARD OF CALIFORNIA for related discussion).

The recent DCA legal opinion has served to heighten the debate over a problem of which BDE is acutely aware. Under Business and Professions Code section 1638 et seq., oral and maxillofacial surgery is defined as “the diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects which involve both functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.” BDE may issue a special permit to practice oral and maxillofacial surgery to (1) a person licensed as a physician under the Medical Practice Act, and who possesses a license to practice dentistry in another state but is not a licensed dentist in California; or (2) a licensed dentist who furnishes satisfactory evidence that he/she is currently certified or eligible for certification in oral and maxillofacial surgery by a specialty board recognized by the Commission on Accreditation of the American Dental Association. However, single-degreed DDS-trained oral and maxillofacial surgeons (OMS) who hold the special permit to engage in oral and maxillofacial surgery are bound by the definition of dentistry set forth in section 1625, while “double-degreed” physicians (MD/DDS) who hold the Board’s special permit are not so bound. For years, single-degreed oral and maxillofacial surgeons have argued that section 1625 prevents them from utilizing the full scope of their oral and maxillofacial surgery training.

In the past, BDE’s position has been that if the dentists represented by CAOMS want legislative clarification of this matter, they should approach the legislature directly; further, BDE has left it to the Medical Board to pursue dentists who are exceeding the scope of their OMS permit. However, due to the issuance of the DCA legal opinion, representatives of BDE, MBC, and CAOMS met with Anne Sheehan, Undersecretary of the State and Consumer Services Agency, on December 9 to discuss the matter. According to BDE, all parties agreed that, as a first step toward resolution of this matter, BDE must become involved in this issue, and should assume responsibility for enforcing the scope of practice of its OMS permit. Thus, BDE must develop a reasonable standard against which to measure the appropriate scope of practice of the OMS as soon as possible. At this writing, BDE is determining the steps necessary to reach this goal, and is expected to discuss this matter further at its January meeting.

Independent Practice Associations / Dental Management Service Organizations. Over the past few years, BDE has received an increasing number of inquiries regarding independent practice associations (IPAs) and dental management service organizations (DMSOs), and even a few applications to operate IPAs in California. Although the Board was advised in 1995 that neither type of business arrangement is lawful under the Dental Practice Act ([15.4 CRLR 76–77]), the growing number of inquiries received prompted the Board to seek guidance from its DCA legal counsel, Christopher Grossgart.

On October 20, Grossgart issued a memorandum which “is not intended to be a definitive position on IPAs and DMSOs” under the Dental Practice Act, but is intended “to help the Board determine whether such entities are consistent with consumer protection, and therefore desirable in California.” If the Board takes such a position, Grossgart reiterated that legislation is needed because IPAs and DMSOs are not recognized or permitted under the current Dental Practice Act.

Grossgart defined an IPA as “an organization of independent dentists which contracts with health care service plans (HCSP) and other managed care entities to provide a specified range of dental services to the HCSP’s enrollees for a predetermined monthly capitation or reduced fee-for-service payment schedule.” The IPA “can be a practice-building mechanism which allows independent dentists to compete more effectively for large HCSP contracts.” Noting that the Dental Practice Act neither expressly authorizes nor prohibits IPAs, Grossgart opined that several provisions of the Act “are inconsistent with, and therefore effectively preclude, the operation of dental IPAs in California.”

For example, Business and Professions Code section 1625 defines the practice of dentistry to include the offering of dental services; to the extent that the IPA offers professional services of its participating dentists to an HCSP, it is practicing dentistry without a license. Further, Business and Professions Code section 1658.1 (the so-called “additional office rule”) prohibits a dentist from operating more than one place of practice unless he/she is “in personal attendance at each place of practice at least 50 percent of the time such places of practice are open for the practice of dentistry.” The term “place of practice” includes “any place of practice in which the [dentist]...holds any right to participate in the management or control thereof.” According to Grossgart, the IPA arrangement violates this law as well, because “when a dentist authorizes the IPA to contractually bind him or her to provide services for predetermined prices, that dentist is allowing the IPA to participate in practice management. Consequently, every dentist who participates in the IPA is subject to the additional office rule, such that he or she must be present in every other participating office at least 50% of the time those offices are open for the practice of dentistry.”

Finally, Grossgart noted that several IPAs have attempted to become registered as dental referral services under Business and Professions Code section 650.2. However, that section states that it “shall not be construed in any manner which would authorize a referral service to engage in the practice of dentistry.” Because IPAs practice dentistry when they offer the services of their participating dentists to HCSPs, they may not be operated under the referral service statute.
Grossgart defined a DMSO as "a business entity which provides various business-related services to dental practices." In other states, a DMSO may contract to oversee limited aspects of a dentist's practice (such as purchasing office supplies and equipment, or arranging for janitorial, telephone, and other services) or it may purchase the bulk of a practice's assets (including equipment and the dental office building) and then lease those assets back to the dentist; "DMSOs may even purchase the practice itself, and hire the former owner to perform dentistry as an employee or independent contractor." However, none of this is lawful in California because of the very broad definition of the "practice of dentistry" in Business and Professions Code section 1625, which provides that a person practices dentistry when he or she "manages or conducts as manager, proprietor, conductor, lessor, or otherwise, a place where dental operations are performed."

At its November meeting, BDE agreed to appoint an ad hoc committee to research this complex issue, and report its findings and recommendations to the Board at a later date.

**Board Delegates Rulemaking Authority to Executive Officer**

At its November 6 meeting, the Board voted to delegate to its executive officer the authority to adopt final regulatory language that is (1) noncontroversial; (2) has been published and has been the subject of no comments and no request for public hearing; and (3) has been preapproved by the Board.

**Legislation**

**AB 745 (B. Thompson),** as amended June 24, makes several changes in the statutes which establish BDE's permit program for the administration of general anesthesia and/or conscious sedation (GA/CS) to patients in a dental office, and prohibit dentists from administering or supervising the administration of GA/CS to patients on an outpatient basis unless the dentist has a permit issued by BDE.

AB 745 permits a licensed physician to administer general anesthesia to dental patients in the office of a licensed dentist, whether or not the dentist has a GA/CS permit, if the physician holds a valid GA/CS permit issued by BDE; authorizes BDE to conduct onsite inspections and evaluations of the dental office, and requires automatic suspension of the physician's permit if he/she fails the inspection; requires the Medical Board of California (MBC) to verify with BDE that a permit applicant is a licensed physician who has successfully completed an approved training program; provides that a physician's violation of these provisions may constitute unprofessional conduct under the Medical Practice Act, and may be grounds for suspension or revocation of the GA/CS permit issued by BDE; and requires BDE to refer physician misconduct to MBC for further disciplinary action. This bill was signed by the Governor on September 15 (Chapter 513, Statutes of 1998).

**AB 2006 (Keeley),** as amended August 11, adds section 1647.10 et seq. to the Business and Professions Code; the bill requires BDE to create a new certification program for dentists who seeks to administer, or order the administration of, oral conscious sedation for patients under 13 years of age, and prohibits any dentist—on and after December 31, 1999—from administering oral CS on a minor patient unless the dentist (1) possesses a current license in good standing to practice dentistry in California and holds either a valid GA permit, a CS permit, or a certificate from the Board pursuant to new section 1647.12 authorizing the dentist to administer oral sedation to minor patients; or (2) possesses a current permit issued by BDE under section 1638 or 1640, and either holds a valid GA or CS permit or possesses a certificate as a provider of oral CS to minor patients. The bill also establishes educational requirements and qualifications for the certificate to administer oral CS to minor patients; and imposes requirements for the administration of oral CS to a minor patient—including the required physical presence of the dentist in the treatment facility while the patient is sedated and until he/she is discharged. Finally, AB 2006 requires that drugs and techniques used in oral CS to minors have a "margin of safety wide enough to render unintended loss of consciousness likely."

AB 2006 was sponsored by BDE and the California Dental Association (CDA). According to the sponsors, this bill is intended to ensure that all dentists who treat children using oral conscious sedation are properly trained. CDA states that in recent months, new concern has focused on the use of oral sedative medications for pediatric dental patients. CDA asserts that oral sedation is used from time to time by nearly 50% of the dentists practicing in California, and that dentists are trained in its proper use as part of its curriculum; however, because of an increase in the number of incidents involving oral sedation in recent years, some additional up-front training and continuing education is warranted for dentists using oral conscious sedation on children. AB 2006 was signed by the Governor on September 15 (Chapter 513, Statutes of 1998).

**AB 2003 (Strom-Martin),** as amended August 24, adds section 1367.71 to the Health and Safety Code and section 10119.9 to the Insurance Code, requiring specified health care service plan contracts and disability insurance policies, commencing January 1, 2000, to cover general anesthesia and associated facility charges for dental procedures for enrollees under seven years of age, or who are developmentally disabled, or for whom general anesthesia is medically necessary, if rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. The bill would authorize the health care service plan to require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions. AB 2003 was signed by the Governor on September 23 (Chapter 790, Statutes of 1998).

**AB 2063 (Cardenas),** as amended June 30, amends Business and Professions Code section 1758 to require ROH candidates to complete an RDH educational program that is accredited by the Commission on Dental Accreditation and conducted by a degree-granting, postsecondary institution; pass an examination required by the Board; and satisfactorily...
AB 2387 (Baugh), as amended August 25, adds section 14124.12 to the Welfare and Institutions Code, and prohibits—until July 1, 2003—the Department of Health Services from reimbursing a disciplined health care provider who is on probation for any Medi-Cal claim for the type of service or procedure that gave rise to the probation. This bill also requires BDE and other health care licensing agencies to work in conjunction with DHS to provide all information that is necessary to implement this provision. This bill was signed by the Governor on September 27 (Chapter 892, Statutes of 1998).

SB 2239 (Committee on Business and Professions), as amended August 24, makes several technical changes in the Dental Practice Act. It amends Business and Professions Code section 1621.1 and repeals section 1621.2 to modify the composition of the Board’s Examining Committee. SB 2239 amends section 1632 to require each applicant for a dentist’s license to give clinical demonstrations of his/her skill in operation with DHS to provide all information that is necessary to demonstrate of his/her judgment in diagnosis-treatment planning. SB 2239 also amends section 1763 to provide written demonstration of judgment in dental diagnosis and treatment planning. The bill also requires each applicant for examination in California to successfully complete the National Board of Dental Examiners’ written examination; successful passage of the National Board’s written exam satisfies section 1632’s requirement of a written demonstration of judgment in dental diagnosis and treatment planning. SB 2239 also amends section 1763 to repeal a requirement that dentists who employ extended function auxiliaries obtain seven units of continuing education in the management and utilization of such auxiliaries. This bill was signed by the Governor on September 26 (Chapter 878, Statutes of 1998).

SB 2238 (Committee on Business and Professions), as amended August 26, requires BDE to initiate the rulemaking process by June 30, 1999 to adopt regulations requiring its licensees to identify themselves to patients as licensed by the state of California. SB 2238 also requires BDE to report the method used for periodic evaluation of its licensing examinations to the DCA Director by December 31, 1999. This bill was signed by the Governor on September 26 (Chapter 879, Statutes of 1998).

AB 1439 (Granlund), as amended August 28, requires health care practitioners to wear a name tag indicating their license status; exempted from this requirement are health care practitioners who work in an office or practice and whose licenses are prominently displayed, and those who work in a psychiatric setting or in a setting that is not licensed by the state. This bill was signed by the Governor on September 29 (Chapter 1013, Statutes of 1998).

AB 2721 (Miller), as amended August 10, establishes a four-year term of office, expiring on June 1, for members of the Board and other DCA agencies. This bill also provides that individuals regulated by DCA agencies who engage in, or aid and abet, prostitution-related offenses in the workplace are guilty of unprofessional conduct and subject to disciplinary action and fines up to $5,000. This bill was approved by the Governor on September 29 (Chapter 971, Statutes of 1998).
precludes it from using Knox’s dental charts and records, or from putting on its full case as to other charges against Sedler not involving Lisa H. The California Supreme Court denied the Board’s petition for review on December 16.

On September 29, the U.S. Supreme Court decided to review the U.S. Ninth Circuit Court of Appeal’s decision in California Dental Association v. Federal Trade Commission, 128 F.3d 720 (9th Cir. 1997), in which the court agreed that the Federal Trade Commission has jurisdiction over CDA, and that CDA’s advertising restrictions unreasonably restrain trade in violation of section 1 of the Sherman Act and section 5 of the FTC Act, justifying the FTC’s issuance of a cease and desist order.

Part of the American Dental Association, CDA is a non-profit trade association for licensed dentists in California; about 70% of dentists licensed in California belong to CDA. In exchange for membership fees, CDA members are provided with a variety of services, including lobbying, marketing and public relations, seminars on practice management, and continuing education courses; CDA also has several for-profit subsidiaries from which members can obtain liability and other types of insurance, financing for equipment purchases, long distance calling discounts, auto leasing, and home mortgages.

As a condition of membership, dentists agree to follow CDA’s Code of Ethics, which are interpreted via advisory opinions issued by a “judicial council” within CDA and supplemented by numerous guidelines which purportedly help members comply with California law. CDA asserted, and the court accepted, that “the state Board of Dental Examiners generally does not pursue violations of state laws on advertising by dentists, and CDA has attempted to fill in the gap with its own enforcement efforts.”

CDA’s advertising guidelines require price advertising to be “exact, without omissions, and shall make each service clearly identifiable without the use of such phrases as ‘as low as,’ ‘and up,’ ‘lowest prices,’ or words or phrases of similar import.” According to the court, “restrictions on the ability to advertise at all... or practices; federal law limits FTC jurisdiction over “corporations” to a company or association, “incorporated or unincorporated...which is organized to carry on business for its own profit or that of its members.” CDA argued that its nonprofit status precludes FTC jurisdiction. After examining decisions by other circuits, the court disagreed with CDA, holding that CDA “is engaged in substantial business activities that provide tangible, pecuniary benefits to its members....The FTC is not purporting to regulate the CDA’s charitable or education activities;...the Commission is concerned with CDA behavior that directly affects the profitability of its members’ practices. Under these circumstances, the FTC properly exercised jurisdiction over the CDA.”

On the merits, the court upheld the FTC’s cease and desist order. It disagreed with the Commission’s finding that CDA’s advertising restrictions are per se unlawful; but sustained the Commission’s use of the abbreviated “quick look” rule of reason analysis (“designed for restraints that are not per se unlawful but are sufficiently anticompetitive on their face that they do not require a full-blown rule of reason inquiry”) and its conclusion that CDA’s price advertising restrictions are unreasonable. “The restrictions CDA placed on price advertising amounted in practice to a fairly ‘naked’ restraint on price competition itself....[P]rice advertising is fundamental to price competition—one of the principal concerns of the antitrust laws.” According to the court, “restrictions on the ability to advertise prices normally make it more difficult for consumers to find a lower price and for dentists to compete on the basis of price....This is particularly true of a restriction on advertising price discounts, a significant basis of price competition.”

The court also sustained the FTC’s finding that CDA’s nonprice advertising restrictions are unlawful. “These restrictions are in effect a form of output limitation, as they restrict the supply of information about individual dentists....Limiting advertisements about quality, safety and other non-price aspects of service prevents dentists from fully describing the package of services they offer, and thus limits their ability to compete.”

At this writing, the U.S. Supreme Court is scheduled to hear oral argument in CDA v. FTC on January 13.

Recent Meetings

At its November meeting, BDE elected its officers for 1999. Robert Christofferson, DDS, was elected President; Roger Simonian, DDS, was elected Vice-President; and Kit Neacy, DDS, was chosen to serve as Secretary.

Future Meetings

• March 18–19, 1999 in San Francisco.
• May 13–14, 1999 in San Diego.
• August 19–20, 1999 in San Francisco.
• November 4–5, 1999 in Sacramento.