KEY FINDINGS

Analysis of California Assembly Bill 350 Fluoride Treatments

Summary to the 2025-2026 California State Legislature, April 13, 2025

Summary

The version of California Assembly Bill (AB) 350 analyzed by the California Health Benefits Review Program (CHBRP) would require coverage of fluoride varnish provided in medical settings for enrollees aged 20 and younger. In 2026, 24.1 million Californians (63% of all Californians) enrolled in state-regulated health insurance would have insurance subject to AB 350.

Benefit Coverage

Benefit coverage for fluoride varnish in medical settings would increase from 4.8% at baseline to 100% postmandate. All enrollees have coverage for fluoride varnish when applied to enrollees aged 0 to 5 years in medical settings at baseline. AB 350 would not exceed essential health benefits (EHBs).

Medical Effectiveness

Overall, CHBRP found evidence that fluoride varnish is effective in the prevention of tooth decay and dental caries, primarily in younger children, in both medical and other clinical settings when applied 2 to 4 times per year.

Cost and Health Impacts[1]

In 2026, CHBRP estimates that AB 350 would result in an additional 139,900 Californians aged 6 to 20 years receiving one application of fluoride varnish at their annual well-child visit. Because of existing benefit coverage, utilization would not change among enrollees aged 0 to 5 years.

AB 350 would increase total premiums paid by employers and enrollees for newly covered benefits by $3,242,000. CHBRP assumes cost sharing would not be charged and therefore projects no changes in enrollee expenses. Total net expenditures would increase by the same amount as premiums (approximately 0.002% of total expenditures).

Context

Untreated dental cavities or carious lesions (resulting from dental caries disease) can lead to pain/sensitivity, abscesses, and subsequent tooth loss. Among young children, it can further lead to delayed eruption or malformation of permanent teeth. Dental caries is the most common chronic condition in the pediatric population in the United States.[2]

Fluoride is a mineral that helps to prevent cavities and to heal early cavities. Fluoride varnish is a topical form of fluoride and the average application time is less than 2 minutes to “paint” the tops and sides of teeth using a small brush. Varnish dries quickly and patients can return to school and eat after application but are advised not to brush their teeth that night.

Bill Summary

Broadly speaking, AB 350 would require coverage of fluoride varnish when provided in a primary care setting for enrollees aged 20 and younger. CHBRP assumes primary care setting means primary care **medical setting**. There are existing coverage requirements for commercial/ California Public Employees’ Retirement System (CalPERS) plans and policies, along with Medi-Cal, for fluoride varnish provided in medical settings for enrollees aged 0 to 5 years.

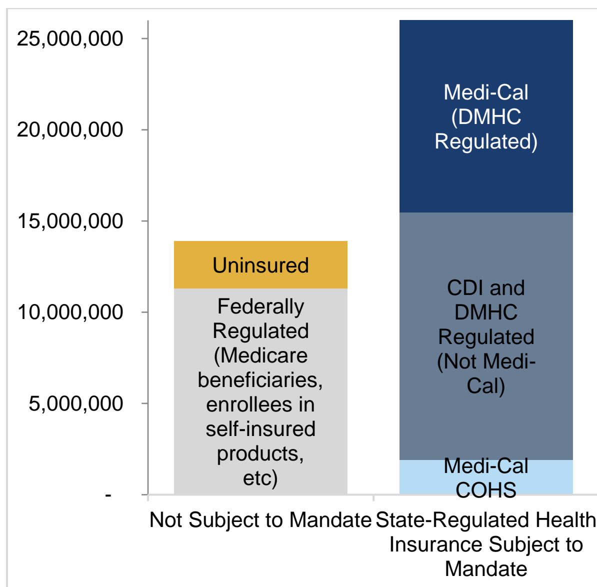
Under existing law, fluoride varnish is a billable service when provided by any person operating under the direction and supervision of a physician or dentist.

Figure A notes how many Californians have health insurance that would be subject to AB 350.

[1] Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

[2] Refer to CHBRP’s full report for full citations and references.

Figure A. Health Insurance in CA and AB 350



Source: California Health Benefits Review Program, 2025.
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DMHC = Department of Managed Health Care.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

Impacts

Benefit Coverage

CHBRP assumes that 100% of enrollees have coverage for fluoride varnish when applied in a primary care setting for enrollees aged 0 to 5 years in accordance with state and federal law. For fluoride varnish applied to enrollees aged 6 to 20 years in medical settings, approximately 1.5% of enrollees in commercial/CalPERS plans and policies and 17% of Medi-Cal beneficiaries have coverage at baseline. Postmandate, all enrollees would have coverage for fluoride varnish provided in a medical setting for children aged 20 years and younger.

Utilization

CHBRP assumes utilization of fluoride varnish among commercial/CalPERS and Medi-Cal enrollees aged 0 to 5 years would not increase because this service is fully covered at baseline. There are approximately 16,600 applications among commercial/CalPERS enrollees aged 0 to 5 years and 115,500 applications among Medi-Cal beneficiaries aged 0 to 5 years at baseline.

CHBRP assumes enrollees who newly receive fluoride varnish postmandate would receive one application within a plan year during the annual well-child visit.

Commercial/CalPERS: For enrollees aged 6 to 20 years, CHBRP estimates approximately 700 billed applications occur in medical settings at baseline. CHBRP estimates utilization would increase by 27,100 applications for a total of 27,800 being billed postmandate.

Medi-Cal: For beneficiaries aged 6 to 20 years, CHBRP estimates approximately 9,000 applications occur in medical settings at baseline. CHBRP estimates utilization would increase by 112,800 applications for a total of 121,800 applications being billed postmandate.

Expenditures

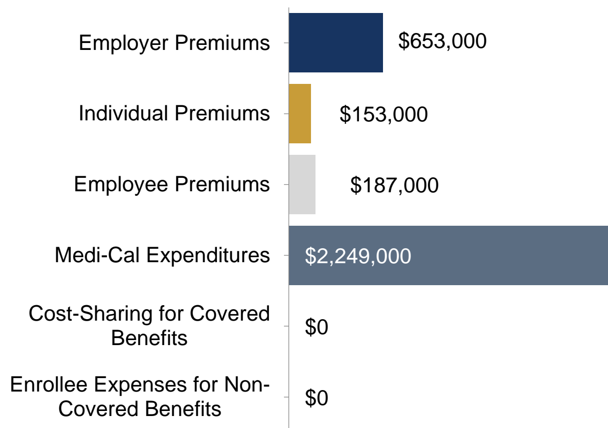
For state-regulated commercial/CalPERS plans and policies and Medi-Cal, AB 350 would increase total premiums paid by employers and enrollees for newly covered benefits by $3,242,000 (Figure B).

Although state and federal preventive services mandates require health plans and policies to cover fluoride varnish provided in a medical setting for enrollees aged 0 to 5 years without cost sharing, there is no corresponding requirement in AB 350 for fluoride varnish provided to enrollees aged 6 to 20 years. CHBRP assumes when fluoride varnish is applied for enrollees aged 6 to 20 years, cost sharing would not be charged because the varnish is applied during a well-child visit.

Therefore, CHBRP projects no changes in enrollee expenses for covered benefits.

Within DMHC-regulated commercial/CalPERS plans and CDI-regulated commercial policies, premiums would increase by $653,000. This would be between 0.0007% and 0.0009% per member per month (PMPM) or between $0.006 and $0.007 PMPM.

Figure B. Expenditure Impacts of AB 350



Source: California Health Benefits Review Program, 2025.

Medi-Cal

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans and County Organized Health Systems (COHS), premiums would increase by $2,249,000. This would be less than 0.01% or $0.02 PMPM.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 350.

Medical Effectiveness

Overall, CHBRP found evidence that fluoride varnish is effective in the prevention of tooth decay and dental caries, primarily in younger children, in both medical and other clinical settings.

In **medical settings**:

- For primary teeth, CHBRP found *strong evidence*[3] that fluoride varnish is effective in improving oral health outcomes such as the prevention of tooth decay and dental caries compared to no fluoride varnish.
- For permanent teeth, there was *not enough research*[4] to determine the effectiveness of fluoride varnish compared to no fluoride varnish on health outcomes. CHBRP notes that absence of evidence is not evidence of no effect.

In **other clinical settings**:

- For primary and permanent teeth, CHBRP found *strong evidence* that fluoride varnish is effective in improving oral health outcomes, such as the prevention of tooth decay and caries, compared to no fluoride varnish, among children younger than 18 years.

Studies identified through this literature review included children younger than 18 years. CHBRP did not identify studies that examined the use of fluoride varnish in medical or other clinical settings for persons aged 18 to 20 years.

Public Health

CHBRP projects a very limited public health impact on the overall incidence of dental caries and loss of tooth enamel due to AB 350 in the first year postmandate. Because 139,900 additional enrollees aged 6 to 20 years would receive one application of fluoride varnish at a well-child visit within the first year (in contrast to the recommended 2 or 4 applications per year), there appears to be no significant impact at the population level during the first year postmandate.

This incremental change in utilization represents about 2% of the 6.32 million enrollees aged 6 to 20 years with state-regulated health insurance. It is unknown whether these children also would receive additional fluoride varnish through other sources such as a dental home or school.

[3] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.

[4] *Not enough research* indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

The change in utilization is limited by barriers to receiving fluoride varnish beyond insurance coverage, such as clinician knowledge about obtaining and applying fluoride varnish, difficulties integrating oral health screening and fluoride varnish application into the workflow, clinician hesitancy due to perceived harms of the varnish, concerns about inadequate or rejected reimbursement, and inadequate office visit time and parent hesitancy.

Dental cavities generally take 1 to 2 years to develop; therefore, in the first year postmandate, the number of cavities averted would be low.

AB 350's very limited impact at the population level also would result in no change in existing racial/ethnic, income, and geographic disparities in incidence of dental caries.

CHBRP notes that, despite very limited impact in the short term, at the person-level, some children may see a reduction in cavities or tooth loss that would have otherwise occurred, as well as potential reductions in cascading consequences such as pain, lost school days (and lost workdays for caregivers), and additional dental work.

Long-Term Impacts

The long-term public health impact associated with AB 350 (reduction in dental caries, associated health and quality of life impacts, and related disparities) may be greater than the first year postmandate due to the expected time course for fluoride to prevent dental caries as well as potential reductions in clinician barriers. Additionally, other public health changes (i.e., community water fluoridation) may attenuate or increase the impact of AB 350.

Assuming enrollees continue to receive fluoride varnish in a medical setting annually, AB 350 could potentially result in a reduction of 5,800 cavities among the 27,100 new users aged 6 to 20 years with commercial/CalPERS coverage and a reduction of 24,200 cavities among the 112,800 new users aged 6 to 20 years with Medi-Cal. This would potentially result in a reduction in expenditures for commercial dental insurers and enrollees of $660,000 and a reduction in expenditures for the Medi-Cal dental program of $1,508,000 over a 4-year period.

Essential Health Benefits and the Affordable Care Act

AB 350 would not exceed the definition of EHBs in California because AB 350 would expand existing benefit coverage and does not create a new coverage requirement.