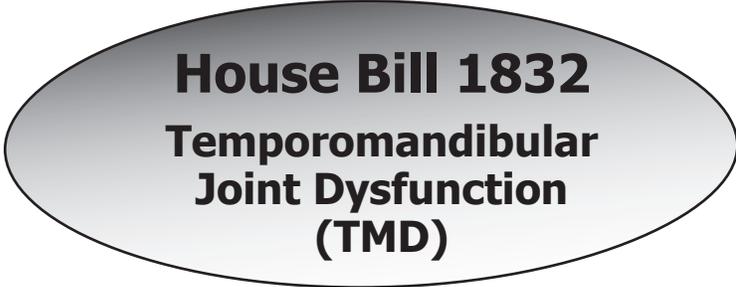


Mandated Benefits Review



**House Bill 1832
Temporomandibular
Joint Dysfunction
(TMD)**

**The Pennsylvania Health Care
Cost Containment Council**

May 2000

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Executive Summary

After reviewing the analysis of House Bill 1832 – legislation that calls for the coverage of treatment for temporomandibular joint dysfunctions (TMD) – the Pennsylvania Health Care Cost Containment Council finds that insufficient information was received to reasonably determine a cost benefit analysis and, therefore, cannot recommend the passage of this legislation at this time. While the Council is sympathetic to those Pennsylvanians suffering from TMD and acknowledges the burden of this condition, neither proponents nor opponents submitted sufficient documentation in accordance to Act 34 of 1993 to determine cost effectiveness.

A reasonable cost estimate to determine the effectiveness of House Bill 1832 could not be developed. Based on the available information, a low cost figure of approximately \$377 million could be estimated; however, if the \$25,000 lifetime maximum cap is employed by just 10 percent of the eligible population, the total costs for non-surgical treatments could reach \$1.5 billion. And if 50 percent of the eligible population reach the maximum cap, the cost for non-surgical treatments could reach \$7.4 billion. While it is reasonable to assume that some patients might reach the cap of \$25,000 and others might receive just one or two of the lowest cost non-surgical treatments, no information was provided to the Council to estimate how many TMD patients would receive which treatments. Therefore, insufficient information was available to narrow these cost estimates.

In addition, we note the following points:

- Proponents point out that the National Institutes of Health support conservative TMD treatments as a first course of action. Supporters claim that early intervention with conservative therapies will prevent most surgical procedures, therefore, reducing health care costs. While there were claims that the passage of House Bill 1832 would result in savings in health care dollars, no studies or data supporting this issue were made available to the Council nor could we locate any in our independent research. The Council strives to determine the cost benefit of health care insurance mandates. Because there was insufficient information, the Council could not determine a cost savings in mandating coverage for the treatment of TMD.
- Since there is no generally established protocol for treating TMD, issues regarding the effectiveness of TMD treatments were raised. For instance, the Council points to a study by the National Institutes of Health and the National Institute of Dental Research, *Management of Temporomandibular Disorders*. This study concluded, “The efficacy of most treatment approaches for TMD is unknown, because most have not been adequately evaluated in long-term studies and virtually none in randomized controlled group trials. Although clinical observation can provide direction, these insights must be followed by rigorous scientific evaluation.” Because one of the Council’s charge is to focus on health care quality, there is particular concern about a mandate where scientific based guidelines for diagnosis and management are unavailable.
- Conflicting information exists regarding the current level of coverage for TMD treatments. Some suggest that only *surgery* is likely to be covered and others said that only *non-surgical* treatments are likely to be covered. There is disagreement, also, among insurers whether TMD should be provided as a dental or medical benefit. Because conflicting information was submitted regarding the current level of coverage for non-surgical and surgical treatments, it was not possible to determine the extent of coverage.
- Finally, the Council’s enabling legislation provides for a preliminary review of submitted materials to determine if documentation received is sufficient to proceed with the formal Mandated Benefits Review process outlined in Act 34 of 1993. We conclude that neither supporters nor opponents of the bill provided sufficient information to warrant a full review by a

Mandated Benefits Review Panel; nor, given the documentation received, do we believe a panel of experts would come to conclusions different than the ones reached here.

The Council suggests that caution must be used when considering health care mandates. In particular, attention must be given to the cumulative financial impact of enacting mandates. It should also be remembered that while mandates increase the cost of health insurance generally, a state mandate will cover, on average, only 42% of the state's population (only 33% of the state's population if the mandate applies only to group plans).

The rise in the number of uninsured Pennsylvanians is of particular concern. The Health Insurance Association of America (HIAA) has reported that the number of uninsured under age 65 in Pennsylvania has jumped 34% since 1991, more than double the national increase of 16%. The role of mandates in this trend is not clear. It can be noted, however, that the number of mandates in Pennsylvania (currently almost 30) has grown in concert with rising costs of health insurance and the growing number of uninsured.

The Council contends that some mandates may be cost effective. For others, however, the balance is not clear. While the Council is sensitive to issues surrounding the coverage of TMD treatments, studies related to the cost benefit and treatment protocols were not provided to the Council to determine that coverage of TMD treatments would be cost effective.

Review of House Bill 1832

Overview of House Bill 1832

House Bill 1832 requires health insurance policies to provide coverage for the treatment of temporomandibular joint dysfunction (TMD) and surgery, if medically necessary, for deformities of the lower jaw.

TMD refers to a collection of medical and dental conditions affecting the jaw joint (temporomandibular joint) as well as the muscles that control chewing. When the joints are out of place, they may cause complications. Among the most common are the inability to open the mouth wide and a clicking or popping sound that is heard when the mouth opens and closes. In some cases, the jaw locks into one position and it is temporarily unable to move. Muscle spasms occur with displaced jaw joints, which can cause migraines, ringing in the ears, loss of hearing, tooth pain, blurred vision, dizziness, and neck, shoulder, or back pain. The primary problem can be in the joints, the muscles of the face and jaw, or a combination.¹

Under House Bill 1832, health insurance policies may not exclude or restrict coverage for any non-surgical or surgical treatment for TMD or functional deformities of the maxilla and mandible that is determined medically necessary by a licensed professional who is qualified by education, training, and experience.

Furthermore, surgical procedures for TMD shall be applied to the lifetime maximum of a health insurance policy and non-surgical procedures are limited to \$25,000 of the lifetime maximum of the policy.

Another component of House Bill 1832 is that insurers would require preauthorization for coverage. In addition, providers must use a uniform preauthorization request form and follow certain standards to determine whether treatment is medically necessary.

In 1992, the Council reviewed Senate Bill 525 which called for the coverage of procedures involving a bone or joint of the skeletal structure. In reviewing House Bill 1832, the Council did not reference materials submitted for the review of Senate Bill 525 since the language of the two bills are very different.

The Mandated Benefits Review Process

The Pennsylvania Health Care Cost Containment Council's enabling legislation, Act 89 of 1986 (as re-authorized by Act 34 of 1993), provides that the Council review proposed mandated health benefits when requested by the Secretary of Health or appropriate committee chairmen of the Pennsylvania Senate or House of Representatives.

In November 1999, Representative Nicholas A. Micozzie, Chairman of the House Insurance Committee, requested that the Council review the provisions of House Bill 1832 (PN 2249, Representative Jerry L. Nailor).

Notification was published in the Pennsylvania Bulletin (December 11, 1999) requesting that interested parties submit documentation and information pertaining to the bill to the Council by February 11, 2000. Letters were also sent to potentially interested individuals and organizations informing them of the pending review and inviting them to submit documentation pursuant to the notice. Following the initial comment period, an opportunity was provided for interested individuals and organizations to examine the responses received and submit additional comments based on that review by March 27, 2000. The Pennsylvania Department of Health and the Pennsylvania Insurance Department were notified of the review and received a copy of the submissions.

A list of the submissions received and a copy of the bill are attached.

Act 34 provides for a preliminary Council review of submitted materials to determine if documentation submitted is sufficient to proceed with the formal Mandated Benefits Review process outlined in the Act. This report presents the results of the Council's preliminary review.

**Analysis of Documentation Submitted by Opponents and Proponents in
Response to the Eight Categories Required by Act 34, Section 9**

(i) *The extent to which the proposed benefit and the service it would provide are needed by, available to and utilized by the population of the Commonwealth.*

In discussing the need for the proposed benefit, Joint Ventures, a TMD support group, estimated that approximately 1.2 to 1.8 million Pennsylvanians suffer from TMD symptoms (nearly 80 percent of these patients are females between the ages of 20 to 40). However, studies supporting this Pennsylvania population figure were not submitted to the Council. On the other hand, opponents argue that it is difficult to estimate the number of individuals affected by TMD, because *diagnosing* TMD is difficult. Opponents argue that since the causes and symptoms of TMD are not clear, there is no standard to correctly identify TMD. In many cases, the patient's description of symptoms, combined with a simple physical examination of the face and jaw, provides the only information for diagnosing this condition.² At the 1996 Technology Assessment Conference, the National Institutes of Health concluded, "There are significant problems with present diagnostic classifications of TMD, because these classifications appear to be based on signs and symptoms rather than on etiology."³

Information received suggests that treatments for TMD are readily available, although treatments vary since the teeth, jaw joints, and muscles can be involved. Treatments for TMD fall into two main categories: conservative and non-conservative. Examples of conservative treatments include eating soft foods, stretching and relaxing exercises, applying heat or ice packs, and muscle relaxing and anti-inflammatory drugs. Another conservative treatment is a splint, which is a plastic guard that fits over the upper and lower teeth. The splint can reduce grinding, which eases muscle tension.⁴ According to a statement released by the National Institute of Dental Research and the National Institutes of Health, "most individuals will experience improvement or relief of symptoms with conservative treatment, the vast majority of TMD patients should receive initial management using noninvasive and reversible therapies."⁵

When conservative treatments have failed, surgery can be performed. One provider noted in a submission that "most patients do not choose to have surgery, an irreversible procedure. In the past ten years, I have not referred a patient for surgery." Submissions noted that only five to eight percent of TMD cases require surgery and it is not always successful in treating this condition.⁶ However, according to the Association of Oral and Maxillofacial Surgeons, "Recent developments in modalities for diagnostic imaging have enabled oral and maxillofacial surgeons to devise more effective surgical procedures to correct TMD conditions."

Submissions opposing House Bill 1832 noted that the efficacy of most treatments for TMD is unknown. One study submitted to the Council concluded, "many treatments are not supported by research because most have not been adequately evaluated in long-term studies."⁷ In a press release, the National Institutes of Health stated, "The absence of reliable scientific data has led to the confusion among dentists and physicians regarding when and how to treat TMD."⁸

While information submitted addressed this point, the documentation lacked specificity in outlining the extent to which the proposed benefits are needed by, available to, and, especially, *utilized* by the population of the Commonwealth.

(ii) *The extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the Commonwealth.*

According to opponents of House Bill 1832, insurance coverage exists for certain TMD treatments. Highmark, for example, noted that they provide coverage for certain TMD treatments; however, no information was submitted to determine the specific level of their coverage.

The Insurance Federation stated, "When it comes to the more conservative and reversible treatments currently recommended, it may be that most modalities are covered. In addition, they noted that it was more likely that surgery might not be covered.

Proponents, on the other hand, argued that many medical plans in Pennsylvania *do not* provide coverage for non-surgical procedures. They claim that if coverage is provided, it is likely to be for a surgical procedure, which is rarely required for TMD. Joint Ventures noted that House Bill 1832 calls for the coverage of conservative TMD treatments, and adds that conservative treatments for TMD are recommended by the National Institutes of Health as a first course of action.⁹

One provider concurred with Joint Ventures by saying, "Some are forced into surgery since their insurance plan only covers surgery." However, the American Academy of Otolaryngology claimed that "while some patients have dental insurance, coverage is limited, particularly if surgery is needed." They noted that "physicians frequently encounter patients who are denied insurance coverage for treatment."

Since no data was provided to substantiate these claims, it is difficult to assess the level of coverage for non-surgical and surgical treatments.

The Pennsylvania Manufacturers' Association and Highmark suggested that purchasers have the option of including a TMD rider in their insurance policy. According to Joint Ventures, employers often do not purchase riders for TMD, and people with TMD are not being given a choice in selecting this rider through their employer.

The Managed Care Association explained, "The lack of insurance coverage can in part be directly attributed to dramatic variation in standards of care." They stated, "some health plans may offer limited coverage or address TMD on a case-by-case basis." They and other opponents noted that since there is no established protocol to treat this condition, coverage among insurers varies. Furthermore, there is disagreement among insurers as to whether TMD should be covered as a medical or dental benefit. Supporters challenged this issue by citing one court decision that determined TMD to be a medical condition rather than a dental condition. In this legal case, the United States Court of Appeals unanimously decided that the TMD treatment should be paid as a medical expense.

Because there is no standard treatment for TMD, some treatments are considered experimental by insurers. Providing coverage for experimental TMD treatments is a concern of opponents. The National Institute of Dental Research and the National Institutes of Health issued the statement that the "lack of standard treatment protocols accepted across professional specialties means that many patients and practitioners may attempt therapy with inadequately tested approaches."¹⁰ Highmark noted that they exclude coverage for services that are classified as experimental and stated that they provide coverage for services that are "proven to be safe and effective" for their subscribers.

In addressing experimental treatments, Joint Ventures stated, "The effectiveness of a specific treatment can only be determined when applied to each individual. However, in most cases, whether or not the treatment was effective, the claim is denied. There is no sure 'fix' for any health condition." In addition, Joint Ventures claimed that there is no protocol in diagnosing and

treating conditions of the lumbo-sacral spine (lower back); however, there is coverage to relieve lower back pain.

Both opponents and proponents discussed the issue of “medical necessity” in their submissions. Highmark stated, “House Bill 1832 would remove the ability of insurers to define ‘medical necessity’ and places it with the provider based on standards cited by legislation. This provision in the legislation conflicts with our participating provider regulations that state Highmark determines medical necessity.” Joint Ventures noted in their submission that “the determination of medical necessity should be a collaboration between the provider and the insurance company, hence the significance of the pre-authorization form to eliminate insurers concerns with medical necessity, diagnosis, and treatment plan.” Some supporters stated that a clear definition for “medically necessary care” is needed to prevent delays or denials of appropriate treatment for TMD.

With regard to whether a lack of coverage results in financial hardship, Joint Ventures claimed that TMD patients under financial hardship are unable to seek treatment; therefore, they experience chronic and severe pain. A submission from a provider claimed that “the lack of coverage results in inadequate health care. My practice offers a long-term, interest-free payment plan so patients can live a pain-free life.” He added that many patients do not seek treatment, because there is a lack of coverage for this condition.

Opponents, however, argued that it is difficult to estimate the number of TMD patients experiencing financial hardship or inadequate health care. The Insurance Federation of Pennsylvania wrote, “It is simply unknown at this point as to how many treatments are prescribed for TMD and how many treatments are covered. That makes it almost impossible to reach a conclusion about whether there is any health care inadequacy or genuine financial hardship.”

While submissions generally discussed the issue of current levels of insurance coverage and whether financial hardship exists, no data or studies were provided to establish claims made by proponents or opponents.

(iii) The demand for the proposed benefit from the public and the source and extent of the opposition to mandating the benefit.

Demand for House Bill 1832

The Council received supportive submissions and letters from dentists, oral surgeons, a TMD support group, the Pennsylvania Society of Oral and Maxillofacial Surgeons, and the American Academy of Otolaryngology. Supporters indicated that this benefit is needed to assist those Pennsylvanians who experience TMD symptoms.

According to the American Academy of Otolaryngology, “Providing coverage for TMD disorders under House Bill 1832 would ultimately improve the access to and quality of care for patients suffering from TMD.” One provider stated that many patients need the proposed benefit and he added, “my office receives numerous calls from patients on a weekly basis seeking treatment for TMD.”

Joint Ventures maintained that the costs of mandating coverage for TMD treatments would be “miniscule” and not a costly burden on the insurance system. They contended that House Bill 1832 would also reduce the out-of-pocket expenses for people with TMD. In addition, Joint Ventures noted that this legislation would also encourage people with TMD to seek early treatment resulting in a decrease in the overall cost of services.

While proponents made general statements, no specific data was submitted to support these claims. The general information provided to the Council did not demonstrate the full level of demand for this benefit in Pennsylvania.

Opposition to House Bill 1832

Health care purchasers and insurers provided submissions opposing House Bill 1832. Opponents of House Bill 1832 maintain that they cannot support the coverage of a condition such as TMD, where scientific based guidelines for diagnosis and management are unavailable. For example, the Managed Care Association stated, “The Association cannot support a disease-specific mandate where symptoms vary widely among patients who may be treated by a variety of providers and according to a variety of treatment standards.”

In agreeing with the Managed Care Association, the Insurance Federation stated, “This is a mandate to cover every approach to a condition that cannot be definitively diagnosed or effectively treated with any consistency.”

In support of these points, Highmark and the Insurance Federation of Pennsylvania submitted the study *Management of Temporomandibular Disorder* from the National Institute of Dental Research and the National Institutes of Health. The study concluded, “The efficacy of most treatment approaches for TMD is unknown, because most have not been adequately evaluated in long-term studies and virtually none in randomized controlled group trials. Although clinical observation can provide direction, these insights must be followed by rigorous scientific evaluation.”¹¹

Opposition to Mandates in General

The submissions from opponents included arguments against mandates in general. Opponents of mandates include insurers and purchasers of health care coverage, who argue that employers and their employees are in the best position to determine health care coverage options that are suited to their needs from a cost and quality standpoint.

Opposition to mandates in general is based on both cost and policy issues. Among the arguments made were that mandates increase the cost of health insurance and the number of uninsured, provide incentive for large employers to self insure, and have a disproportionate effect on small businesses. The point was made that any one mandate should be considered as contributing to the cumulative effect of mandates on businesses and on their ability to make affordable health insurance available to their employees. Workers end up paying for mandated benefits in the form of reduced wages or fewer benefits, as well as higher insurance premiums.

In support of these points, both Highmark and the Insurance Federation included a study from Milliman and Robertson which emphasizes the cumulative effect of mandates on the cost of health insurance, though it does not mention coverage for TMD. Milliman and Robertson estimated that the cost of 12 of the most common mandates could increase the cost of health insurance by as much as 30%.¹² Pennsylvania has already enacted over 25 mandates, including 6 of the 12 most common discussed by Milliman and Robertson.

A 1999 study by Jensen and Morissey, *The Price of State Mandated Benefits*, supports the contention that mandates cost money. Jensen and Morissey report that in Virginia, Mandates accounted for 21% of claims; in Maryland they accounted for 11 to 22% of claims; and in Massachusetts 13% of claims.¹³

Opponents claimed that the growing number of mandates hurts Pennsylvania’s business climate. In general, the submissions from the business community pointed out that an increase in the cost of health care could encourage businesses to drop coverage for their employees, resulting in a rise in the number of uninsured. Along these lines, the Kaiser Family Foundation reported that

the number of small businesses (under 199) providing health insurance for their workers has declined over the past several years. The study, conducted by KPMG Peat Marwick, found that the percentage of U.S. small business workers receiving employer sponsored health coverage declined from 52% in 1996 to 47% in 1998.¹⁴ When employers who canceled their employees' health insurance policies have been polled on why they did so, the majority claimed that it was because the price was too high. Lower income employees are most likely to lose coverage. Insufficient information was submitted to determine whether these percentages are consistent with the experience in Pennsylvania.

The rise in the number of uninsured Pennsylvanians is an immediate and serious concern. The Health Insurance Association of America (HIAA) has reported that the number of uninsured under age 65 in Pennsylvania has jumped 34% since 1991, more than double the national increase of 16%.¹⁵

In a report by Jensen and Morrissey, they claimed that between 20-25% of uninsured Americans lack coverage because of the cost of benefit mandates.¹⁶ Consumers may be forced into purchasing very expensive benefits or joining the ranks of the uninsured.

Another point noted by opponents is that though increasing the cost of health insurance generally, mandates only benefit a limited percentage of Pennsylvania citizens. Because ERISA preempts self-insured firms from state mandates, a state mandate that applies to private group plans, will cover, on average only 33% of the state's population. One that applies to private group plans *and* individual policies will cover about 42% of a state's population.¹⁷ As the number of mandates increases, studies have indicated that more firms seek to self-insure to avoid being subject to mandates.

In summary, opposition to the proposed legislation involves concerns about this legislation specifically as well as concerns about mandates in general. Purchasers and providers of health insurance are concerned about the impact of mandates on the number of Pennsylvanians without any health insurance, as well as having concerns about the cumulative effects of mandates on Pennsylvania's business climate.

(iv) *All relevant findings bearing on the social impact of the lack of the proposed benefits.*

Joint Ventures argued that people affected by TMD experience a lower quality of life because of the lack of the proposed benefits. They noted that a person with this condition withdraws from family, friends, and co-workers and their work performance deteriorates. TMD patients may also experience anxiety and clinical depression. No data or studies to support these claims were presented to the Council.

A point addressed by opponents is that there is no proof indicating that people with TMD are not seeking treatment because of the lack of the proposed benefit. The Insurance Federation of Pennsylvania noted, "Without any proof that significant numbers of sufferers are going without treatment, it would be pure speculation to conclude that there were a large social impact attendant to the lack of a mandate."

Based on the limited information submitted to the Council, neither opponents nor proponents provided evidence to fully address the issue of social impact.

- (v) ***Where the proposed benefit would mandate coverage of a particular therapy the results of at least one professionally accepted, controlled trial, comparing the medical consequences of the proposed therapy, alternative therapies, and no therapy.***

House Bill 1832 does not call for coverage of a particular therapy; however, it is important to note that a variety of TMD treatments exist. Some of the approaches to relieve TMD symptoms are muscle relaxers, heat massages, chiropractic services, and physical therapy. Psychological counseling is also used to reduce stress and anxiety, which appear to affect TMD. Other treatments are orthodontic. In severe cases, surgery can be performed.

- (vi) ***Where the proposed benefit would mandate coverage of an additional class of practitioners, the result of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits.***

Although House Bill 1832 does not call for coverage of an additional class of practitioners, different types of doctors provide care for this condition, such as dentists, oral surgeons, orthodontists, and chiropractors. Under House Bill 1832, health insurers would be required to provide coverage for treatments that are considered medically necessary by providers who are "licensed professionals qualified by education, training, and experience." Opponents noted that this language is broad and vague. Highmark stated, "This seems to suggest that insurers would have to recognize anyone who professes to meet the criteria. Highmark is limited to reimbursing for services rendered by specific providers, such as MDs, DMDs, etc."

- (vii) ***The results of any relevant research.***

Information regarding research is discussed in other sections of this report.

- (viii) ***Evidence of the financial impact of the proposed legislation, including at least:***

- (A) The extent to which the proposed benefit would increase or decrease cost for treatment or service.***

The Insurance Federation of Pennsylvania noted that the Dental Relations Subcommittee of the Health Insurance Association of America projected conservative treatments range between \$150 to \$6,000 per service and major surgical procedures can range from \$2,500 to \$10,000.

The Council, however, did not receive information addressing the extent to which the proposed benefit would *increase or decrease* the costs for this treatment or service.

- (B) The extent to which similar mandated benefits in other states have affected charges, costs and payments for services.***

While legislation mandating the coverage of TMD treatment has been enacted in 19 states, no state has enacted legislation exactly like House Bill 1832. Minnesota, in 1987, became the first state to adopt legislation requiring health insurance policies to include coverage for the diagnosis and treatment of TMD, which applies whether a physician or dentist provides treatment. Georgia's TMD legislation limits the coverage for non-surgical treatments. Nevada law states that methods of treatment recognized as dental procedures may be excluded and insurers may limit TMD benefits to 50% of usual and customary charges and to treatment which is medically necessary. It is required that TMD benefits are offered as optional coverage in medical and dental group insurance contracts in the state of Washington. Some states included lifetime

maximum caps; however, the highest cap in other states is \$10,000 for surgical and \$2,500 for non-surgical.¹⁸ A law in Wisconsin requires *only* medical policies (dental plans are excluded) to provide an annual limit of \$1,250 coverage for non-surgical TMD treatments and unlimited coverage for surgical procedures. The law also calls for insurance plans to require prior authorization for TMD treatments.¹⁹

One submission from proponents of House Bill 1832 noted that Minnesota was able to determine that providing coverage for TMD treatment caused an increase in the number of patients, a decrease in TMD surgery, and overall costs decreased. This study was not submitted to the Council; and, at the Council's request, officials in Minnesota were unable to provide a copy of this study.

Highmark stated, "Other states have excluded services that add considerable cost to TMD treatment or have added various cost containment mechanisms." Joint Ventures argued, "House Bill 1832 clearly imposes these same cost containment mechanisms. Specifically, treatment is only covered when medically necessary and criteria to establish medical necessity is included in the bill."

The Council suggests that while the information submitted was informative, it is not sufficient in determining the extent to which charges, costs, and payment for services in other states have been affected by such mandates.

(C) The extent to which the proposed benefit would increase the appropriate use of treatment or service.

Supporters of this bill noted that coverage for TMD treatments would result in more appropriate utilization.

In addressing this point, opponents revisited the issue of experimental treatments. They argued that providing coverage for TMD treatments could increase the number of experimental TMD services. Highmark stated, "House Bill 1832 requires insurers to provide coverage for certain unproven and potentially unsafe treatments." Joint Ventures, however, argued that there is coverage for experimental treatments for other health conditions. In addition, they noted that there are other conditions and diseases that have several treatments and remedies for different patients.

Another point made by opponents was that many types of health care providers would seek reimbursement under this mandate since there is no specific certification to treat TMD. Highmark wrote, "This mandate will encourage providers to utilize an extensive number of high cost services in greater volume."

The Managed Care Association concluded that "there is no standard of care to treat TMD and it is unknown how the mandate would increase the appropriate use of treatments."

Although supporters and opponents made general statements regarding this issue, they did not provide data to the Council to determine the extent to which the proposed benefit would increase the appropriate use of treatment or service.

(D) The impact of the proposed benefit on administrative expenses of health care insurers.

According to opponents, all mandates including House Bill 1832 increase administrative expenses. Computer systems, member contracts and handbooks would be upgraded to include the new benefit. Highmark estimated that administering this mandate would cost Highmark companies approximately \$291,000. They also stated, "With House Bill 1832, there would be numerous system changes required to process dental benefits under medical/surgical coverage."

The Managed Care Association pointed out that health plans may “incur the cost of retaining services of oral surgeons or other practitioners to review TMD claims for appropriateness and medical necessity.”

This mandate would require health plans to use two, new standardized forms, which the Managed Care Association and the Insurance Federation of Pennsylvania noted would increase administrative expenses.

Joint Ventures assumed there would be a minimal administrative expense with implementing this benefit. They noted that all health care benefits require procedures for processing claims. Joint Ventures stated, “It is true that this legislation requires a preauthorization form for surgical and non-surgical treatment; however, this is required to alleviate the concerns of insurance companies for this condition.”

The information submitted was not sufficient in determining the specific impact of the proposed benefits on administrative expenses of health care insurers.

(E) The impact of the proposed benefit on the benefits costs of purchasers.

Only the submissions from opponents addressed this issue. They stated that the passage of mandates, in general, impose financial burdens on purchasers. For example, Highmark concluded that the costs of mandates “are passed onto customers, primarily employers, labor groups and individuals. While the cost of mandated benefits varies, it is the cumulative costs that hurt all purchasers of health insurance coverage.” Opponents argued that mandated benefits increase insurance premiums causing employers to either lower wages, decrease benefits, reduce employment, or eliminate health care coverage for their employees.

Based on the submissions, insufficient documentation was provided to the Council to determine the impact of the benefits costs of purchasers.

(F) The impact of the proposed benefits on total cost of health care within the Commonwealth.

In addressing this issue, Joint Ventures stated that TMD is a progressive condition and early intervention for TMD is essential in reducing health care costs. They argued that providing coverage for conservative treatments would result in a lower number of surgeries, therefore decreasing the long term costs. In addition, they argued that “health care providers who treat TMD have developed treatment procedures which not only have proven efficacy, but are very cost effective in comparison to long term cost incurred by the state if sufferers are not treated as a consequence of no insurance coverage.”

Highmark was the only submitter that provided a cost estimate for this mandated benefit. Based on Highmark actuarial estimates, this legislation could increase their annual claim expense by approximately \$5.8 million annually. This projection is based on current and projected claims for Highmark. The Highmark submission did not include specific information regarding how these estimates were calculated (number of claims, cost per claim, etc.).

Opponents made the point that utilization of this benefit is expected to increase the total cost associated with treating TMD and speculated, in particular, that House Bill 1832 would increase the cost of services since it establishes a lifetime maximum of \$25,000 per patient for non-surgical procedures.

While insufficient information was received by the Council to fully determine how this legislation would affect the total cost of health care in Pennsylvania, it was possible to examine some estimates:

Population Affected. According to the information provided by Joint Ventures, approximately 1.2 to 1.8 million Pennsylvanians suffer from TMD symptoms, so an average of 1.5 million was used in estimating costs for TMD treatments. Since approximately 42% of the 1.5 million would be covered under this legislation (the ERISA exempt population and the uninsured population would not be covered), approximately 630,000 would be eligible.

Treatment Costs. Based on submitted information, the cost for conservative treatments range between \$150 to \$6,000 and the cost for a surgical procedure range between \$2,500 to \$10,000. In addition, under this legislation, non-surgical procedures are limited to \$25,000 of the lifetime maximum of the policy.

Projected Cost. If 31,500 TMD patients (five percent of 630,000) receive surgery at the average cost of \$6,250, total costs could reach \$197 million.

Assuming that the remaining 598,000 patients receive two conservative treatments at the lowest cost of such treatment (\$150 per visit), this service could reach \$180 million for a total of \$377 million (\$197 million for surgical plus \$180 million non-surgical).

If only 10% of these 598,000 reach the maximum cap, total costs for non-surgical treatment could reach \$1.5 billion. If 50% of 598,000 reach the maximum cap, the cost could reach \$7.4 billion.

This is a wide range of cost estimates. While it is reasonable to assume that some patients undergoing non-surgical procedures might reach the cap of \$25,000 and others might receive one or two of the lowest cost non-surgical treatments, no information was provided to the Council to estimate how many TMD patients would receive which treatments. Therefore, insufficient information was available to narrow these cost estimates.

Furthermore, while there were claims that the passage of House Bill 1832 would result in savings in health care dollars, no studies or data supporting this issue were made available to the Council nor could we locate any in our independent research. The Council strives to determine the cost benefit of health care insurance mandates. Because there was insufficient information, the Council could not determine a cost savings in mandating coverage for the treatment of TMD.

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- ¹⁵ "PA's Uninsured Growing Twice Rate of Nation." *Metro*. January 24, 2000.
- ^{13, 16, 17} Jensen G, Morrisey M. "Mandated Benefit Laws and Employer-Sponsored Health Insurance." The Health Insurance Association of America. January 1999.
- ¹⁸ American Dental Association. "TM Treatment and Third Party Insurance Coverage." Department of State Government Affairs. February 15, 1999.
- ¹⁹ Wisconsin Dental Association. "Insurance Coverage for TMD." <http://wisconsin dental.com>.

Submissions for House Bill 1832

American Academy of Otolaryngology – Head and Neck Surgery, Inc. (G. Richard Holt, M.D., M.P.H., Executive Vice President)

1. Letter supporting House Bill 1832.

AFLAC – American Family Life Assurance Company of Columbus (Richard J. Gmerek of the Law Offices of Gmerek & Hayden, P.C.)

1. Statement addressing House Bill 1832 and requesting exemptions for certain supplemental policies.

Highmark Blue Cross Blue Shield (Bruce R. Hironimus, Vice President, Government Affairs)

1. Letter opposing House Bill 1832.
2. Statement addressing Section 9 requirements and opposing House Bill 1832.
3. National Institutes of Health. "Management of Temporomandibular Disorders." Technology Assessment Conference Statement. May 1, 1996.
4. Levitt S, McKinney M. "Validating the TMJ Scale in a National Sample of 10,000 Patients: Demographic and Epidemiological Characteristics." *Journal of Orofacial Pain*. 8; 1: 25-35. 1994.
5. National Institute of Dental and Craniofacial Research and the National Institutes of Health. "TMD: Temporomandibular Disorders." <http://www.nidcr.nih.gov/news/pubs/tmd/main.htm>.
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12. Goldstein B. "Temporomandibular Disorders: A Review of Current Understanding." *Oral Surgery Oral Medicine Oral Pathology*. 88; 4: 379-385. October 1999.
13. Dworkin S. "The Case for Incorporating Biobehavioral Treatment into TMD Management." *JADA*. 127:1607-1610. November 1996.
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16. Hilzenrath D. "Health Care Costs Hitting Small Firms Harder." *The Washington Post*. December 14, 1999.
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19. Jensen G, Morrisey M. "Mandated Benefit Laws and Employer-Sponsored Health Insurance." The Health Insurance Association of America. January 1999.
20. Seward A, Henderson J. "Report on the Cost of Health Care System Mandates." Baylor University. January 1999.

The Insurance Federation of Pennsylvania, Inc. (John R. Doubman, Secretary and Counsel)

1. Statement addressing Section 9 requirements and opposing House Bill 1832
2. Resolution 15 passed by the 1989 American Dental Association's House of Delegates. "Offer of Coverage for Treatment of TMD."
3. American Dental Association Workshop on TMD. November 1988.
4. National Institutes of Health. "NIH Panel Makes Recommendations for TMD." May 1, 1996.
5. Katz D. "Employers Seen Facing 18 Percent Drug-Cost Hike." *National Underwriter Property and Casualty/Risk and Benefits Management Edition*. January 24, 2000.
6. "Employers Say They Might Drop Health Benefits Over Liability Fears." *Lancaster Intelligence Journal*. January 1, 2000.
7. "PA's Uninsured Growing Twice Rate of Nation." *Metro*. January 24, 2000
8. Jensen G, Morrisey M. "Mandated Benefit Laws and Employer-Sponsored Health Insurance." The Health Insurance Association of American. January 1999.

Joint Ventures (Donna Sponaugle, President)

1. Letter addressing Section 9 requirements and supporting House Bill 1832.
2. Joint Ventures brochure.
3. "Anatomy of the Temporomandibular Joint."
4. Letter dated March 27, 2000, in response to documentation submitted to the Council.

Aziz A. Majid, D.M.D., M.S.D.

1. Letter supporting House Bill 1832.

Managed Care Association of Pennsylvania (Kimberly J. Kockler, Executive Director)

1. Statement addressing Section 9 requirements and opposing House Bill 1832.

National Federation of Independent Business (James D. Welty, Pennsylvania State Director)

1. Letter opposing House Bill 1832.

Ronald W. Niklaus, D.M.D., M.A.G.D.

1. Letter supporting House Bill 1832.

Oral and Conestoga Maxillofacial Surgery, LTD. (Thomas Yingling, D.D.S. et al)

1. Letter supporting House Bill 1832.

Pennsylvania Chamber of Business and Industry (Floyd Warner, President)

1. Letter opposing House Bill 1832.

Pennsylvania Manufacturers' Association (Jim Panyard, Executive Director)

1. Letter opposing House Bill 1832.

Pennsylvania Society of Oral and Maxillofacial Surgeons (John J. Ciabattoni, D.D.S., President)

1. Letter supporting House Bill 1832.
2. American Association of Oral and Maxillofacial Surgeons Position Paper on Temporomandibular Joint Surgery.

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1832 Session of
1999

INTRODUCED BY NAILOR, CIVERA, MANDERINO, MASLAND, BELARDI,
LYNCH, GEIST, BARRAR, WILT, McNAUGHTON, STABACK, LAUGHLIN,
WOJNAROSKI, HENNESSEY, HALUSKA, FAIRCHILD, FRANKEL, HARHAI,
R. MILLER, ORIE, LaGROTTA, SEMMEL, L. I. COHEN, ARGALL,
ROHRER, SCRIMENTI, E. Z. TAYLOR, MARKOSEK, SCHULER, DeLUCA,
TRELLO, KENNEY, TANGRETTI, M. COHEN, MELIO, PLATTS, JOSEPHS,
STEELMAN AND COLAFELLA, SEPTEMBER 20, 1999

REFERRED TO COMMITTEE ON INSURANCE, SEPTEMBER 20, 1999

AN ACT

1 Amending the act of May 17, 1921 (P.L. 682, No. 284), entitled "An
2 act relating to insurance; amending, revising, and
3 consolidating the law providing for the incorporation of
4 insurance companies, and the regulation, supervision, and
5 protection of home and foreign insurance companies, Lloyds
6 associations, reciprocal and inter-insurance exchanges, and
7 fire insurance rating bureaus, and the regulation and
8 supervision of insurance carried by such companies,
9 associations, and exchanges, including insurance carried by
10 the State Workmen's Insurance Fund; providing penalties; and
11 repealing existing laws," providing for insurance coverage
12 for treatment of temporomandibular joint dysfunction and
13 surgery, if medically necessary, for deformities of the
14 maxilla or mandible.

15 The General Assembly of the Commonwealth of Pennsylvania
16 hereby enacts as follows:

17 Section 1. The act of May 17, 1921 (P.L. 682, No. 284), known
18 as The Insurance Company Law of 1921, is amended by adding a
19 section to read:

20 Section 635.2. Coverage for Treatment of Temporomandibular
21 Joint Dysfunction and Surgery, if Medically Necessary, for

1 Deformities of the Maxilla or Mandible. --(a) (1) This section
2 shall apply to any individual or group health, sickness or
3 accident policy or subscriber contract or certificate issued by
4 any entity subject to 40 Pa.C.S. Ch. 61 (relating to hospital
5 plan corporations) or 63 (relating to professional health
6 service plan corporation), this act, the act of December 29,
7 1972 (P.L. 1701, No. 364), known as the "Health Maintenance
8 Organization Act," or the act of December 14, 1992 (P.L. 835,
9 No. 134), known as the "Fraternal Benefit Societies Code," which
10 provides hospital or medical/surgical coverage.

11 (2) Nothing in this section shall apply to accident only,
12 specified disease, hospital indemnity, Medicare supplement,
13 long-term care or other limited benefit health insurance
14 policies.

15 (b) If an insurance policy, contract or certificate provides
16 coverage for benefits to a resident of this Commonwealth, it
17 shall be deemed to be delivered in this Commonwealth, regardless
18 of whether the insurer issuing or delivering the policy is
19 located within or outside of this Commonwealth.

20 (c) No policy may be issued for delivery in this
21 Commonwealth which:

22 (1) excludes medically necessary nonsurgical or surgical
23 treatment for temporomandibular joint dysfunction by licensed
24 professionals qualified by education, training and experience;
25 or

26 (2) excludes medically necessary surgery for the treatment
27 of functional deformities of the maxilla and mandible.

28 (d) The provisions of this section shall not apply to
29 cosmetic or elective orthodontic or periodontal care or general
30 dental care.

1 (e) Nothing in subsection (c)(1) and (2) shall be construed
2 to prevent the application of the deductible, co-insurance or
3 pre-existing condition limitation or any other terms and
4 conditions contained in the policy, contract or certificate.

5 (f) A definition of pre-existing condition does not prohibit
6 an insurer from using an application form designed to elicit the
7 complete health history of the applicant, and on the basis of
8 the answers on that application, from underwriting in accordance
9 with that insurer's established underwriting standards. Unless
10 otherwise provided in the policy, contract or certificate, a
11 pre-existing condition need not be covered until the waiting
12 period is satisfied, as indicated in the policy, contract or
13 certificate. No policy, contract or certificate may exclude or
14 use waivers or riders of any kind to exclude, limit or reduce
15 coverage or benefits for specifically named or described pre-
16 existing diseases or physical conditions beyond the waiting
17 period described in the policy, contract or certificate.

18 (g) Policies, contracts or certificates shall contain a
19 twenty-five thousand dollar (\$25,000) lifetime maximum for
20 nonsurgical procedures. The lifetime maximum of the policy shall
21 be applied to surgical procedures. The twenty-five thousand
22 dollar (\$25,000) lifetime maximum for nonsurgical procedures
23 does not prevent the company from exercising the option to grant
24 additional benefits for nonsurgical procedures if it is more
25 cost effective than providing benefits for surgery.

26 (h) Ninety (90) days after a nonsurgical procedure, the
27 provider of treatment is required to provide documentation and a
28 narrative, signed by the patient, to the insurer showing the
29 progress of the insured. If the documentation and narrative do
30 not show satisfactory progress, benefits are terminated until a

1 second opinion is received. If the second opinion differs from
2 the treating provider, a revised treatment plan shall be
3 prepared. If the second opinion, due to a valid reason, does not
4 differ from the current treatment, the current treatment shall
5 be continued for an additional ninety (90) days at which time
6 the treatment plan will be re-evaluated.

7 (i) Insurers shall require preauthorization for coverage,
8 and providers of treatment shall use a uniform preauthorization
9 request form and follow certain standards which include
10 evidence-based standards and patient-centered standards in
11 determining whether treatment is medically necessary. The
12 following apply:

13 (1) An insurer shall require a preauthorization for
14 nonsurgical treatment, and the provider of treatment shall
15 submit a properly completed Temporomandibular Joint Dysfunction
16 Nonsurgical Treatment Preauthorization Request Form.

17 (2) An insurer shall require a preauthorization for surgical
18 treatment for coverage, and the provider of treatment shall
19 submit a properly completed Temporomandibular Joint Dysfunction
20 Surgical Treatment Preauthorization Request Form.

21 (3) In cases of emergency, the preauthorization form shall
22 be submitted no later than forty-eight (48) hours after the
23 emergency treatment. Treatment shall be limited to only two (2)
24 emergencies with the same patient in the attending doctor's
25 office within one (1) week without preauthorization prior to
26 treatment providing the preauthorization is submitted no later
27 than forty-eight (48) hours after the emergency treatment.
28 Nothing in this paragraph shall be construed to mean that
29 emergency room treatment may not be obtained if the attending
30 doctor cannot be reached.

1 (4) The following are standards and requirements for
2 evaluation of claims for temporomandibular dysfunction for
3 medical necessity:

4 (i) To evaluate appropriately a claim for treatment of this
5 disorder, the existence of a skeletal dysfunction, muscular
6 dysfunction or skeletal and muscular dysfunction shall be
7 documented.

8 (ii) A maldevelopment that is not treatable with
9 conventional, reversible, nonsurgical treatment, yielding a
10 stable and functional post-treatment occlusion without worsening
11 the patient's original condition, shall be a covered surgical
12 procedure.

13 (iii) Indications for nonsurgical procedures in excess of
14 two hundred dollars (\$200) and all surgical treatments shall
15 include evidence of the following:

16 (A) Physical evidence of musculoskeletal, dento-osseous or
17 soft tissue deformity.

18 (B) Imaging evidence of musculoskeletal, dento-osseous or
19 soft tissue deformity.

20 (C) Malocclusion deviating from a normal occlusal
21 relationship that cannot reasonably be corrected by nonsurgical
22 means such as orthodontics or prosthetics. This item is
23 applicable only as evidence for indication of surgical
24 treatment.

25 (D) An inability to open or close the jaw adequately based
26 on medically accepted range of motion standards. These ranges
27 shall be as follows: forty-eight (48) to fifty-two (52)
28 millimeters vertical and twelve (12) to fourteen (14)
29 millimeters lateral. Adherence to these measurements is
30 recommended. Any deviation should be justified in a report as

1 part of the evidence.

2 (E) A patient history, including the patient's perception of
3 pain, dysfunction and the impact on the patient's quality of
4 life.

5 (iv) The following data shall be submitted so that claims
6 may be evaluated appropriately:

7 (A) A narrative of the patient's clinical condition in
8 conjunction with the Temporomandibular Joint Dysfunction
9 Nonsurgical or Surgical Treatment Preauthorization Form.

10 (B) Mounted study models with appropriate centric record and
11 transcranial x-ray or preferably a corrected tomography. This
12 data may be substituted with appropriate paper documentation
13 using current United States Food and Drug Administration-
14 approved computer imaging systems that have the ability to
15 photograph all necessary information, including, but not limited
16 to, MRI.

17 (j) This section shall not be construed to affect any other
18 coverage required under the acts identified in subsection (a) or
19 to restrict the scope of coverage under any policy, contract or
20 certificate issued or delivered in this Commonwealth to any
21 individual or group.

22 (k) Nothing in this section shall be construed to encourage
23 surgical procedures over appropriate nonsurgical procedures.

24 (l) As used in this section, the term "functional deformity"
25 means a deformity of the bone or joint structure of the maxilla
26 or mandible such that the normal character and essential
27 function of such bone structure is impeded. A "temporomandibular
28 joint" means the connection of the mandible and the temporal
29 bone through the articular disc surrounded by the joint capsule
30 and associated ligaments and tendons. "Temporomandibular joint

1 dysfunction" means congenital or developed anomalies of the
2 temporomandibular joint. An "emergency" means a condition in
3 which immediate medical care is necessary to prevent serious
4 impairment or the death of the individual.

5 Section 2. This act shall take effect in 60 days.