Bureau of Insurance

A Report to the Joint Standing Committee on Insurance and Financial Services of the 123rd Maine Legislature

Review and Evaluation of LD 1429, An Act To Require Insurance Coverage for Temporomandibular Joint Disorders

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I. Executive Summary

The Joint Standing Committee on Insurance and Financial Services of the 123rd Maine Legislature (the Committee) directed the Bureau of Insurance to review LD 1429, An Act To Require Insurance Coverage for Temporomandibular Joint (TMJ) Disorders. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of NovaRest, Inc. and the Maine Bureau of Insurance (the Bureau).

The Committee requested the analysis be based on the following amendments to the bill:

- Require that individual and group health insurance policies provide coverage for musculoskeletal disorders affecting any bone or joint in the face, neck or head if the policy would provide coverage for musculoskeletal disorders affecting other bones or joints in the body;
- Allow for coverage for appropriate medically necessary treatment referred by a physician or a dentist; and
- Exclude coverage for experimental procedures.

The Committee's letter also asked the Bureau to provide information on the current policies and exclusions under health insurance policies and dental insurance policies regarding the treatment of temporomandibular disorders. If this mandate is enacted, the Committee wants to ensure that treatment for these disorders that is considered surgical be covered by health insurance and that treatment with certain appliances or braces are covered by dental insurance.

The requirements of LD 1429 would apply to all medical policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. As currently worded the bill does not apply to dental plans because they are excluded from the definition of health insurance for purposes of mandated benefits pursuant to 24-A M.R.S.A. § 704.

Temporomandibular joint and muscle disorders, commonly called "TMJ" or "TMD," are a group of conditions that cause pain and dysfunction in the jaw joint and the muscles that control jaw movement. We don't know for certain how many people have TMJ disorders, but some estimates suggest that over 10 million Americans are affected. The condition is most common in 20-40 year olds and appears to be more common in women than men.[1] Women on hormone replacement therapy were 77% more likely to

[1] "TMJ Disorders". June 2006. Office of Research on Women's Health. 11 May 2007 <http://www.nidcr.nih.gov/HealthInformation/DiseasesAndConditions/TMDTMJ/TmjDisorders.htm>

seek treatment for jaw pain.[2]

As many as 65% to 85% of the population will develop TMJ problems at some point in their lives. In most cases, the symptoms are mild and go away without treatment. Approximately 12% of TMJ disorders become long-term (chronic) and need ongoing care.[3]

Treatment can vary from rest to extensive surgery. Diagnosis and treatment in the simplest cases can cost $2,500 and 90% of the time, these treatments are sufficient. If more extensive combination therapies are required, the cost can range from $10,000 - $20,000. Surgical solutions can be $50,000 or more.

TMJ treatment often falls into the crack between dental and medical insurance coverage. Dental coverage does not cover some treatments because they are considered medical by the dental insurer, while medical insurers may not cover treatments provided by dentists and oral surgeons. Insureds with both dental and medical coverage can find themselves in a situation where neither insurer covers the treatment for their TMJ condition.

Legislation requiring coverage for TMJ procedures has been passed in 16 states. Four other states require that coverage for TMJ procedures be offered.

A survey of the major health insurers in Maine indicates that:

(1) Anthem Blue Cross currently excludes coverage for treatment of TMJ.
(2) Aetna excludes coverage for treatment of TMJ. A thorough explanation of Aetna's reasoning for the exclusion can be found in Appendix E;
(3) Cigna excludes TMJ from all insured business, but offers services to self-funded customers;
(4) Harvard Pilgrim does cover treatment of TMJ disorders but not dental treatment or appliances.
(4) MetLife dental policies exclude coverage for TMJ, unless the group requests it; and
(5) Delta Dental excludes coverage for TMJ, which they consider a medical condition not related to the teeth or gums. Delta Dental provides coverage to groups, if they specifically request it.

The premium impact for this bill is highly dependent on the cost sharing included in the policy. In a study of the financial impact of a similar law in Texas, The Texas Department of Insurance estimated that the cost was approximately $0.30 per member per month (PMPM) for single coverage and $0.66 per

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[2] "TMJ (Temporomandibular Joint Disease/Disorders)". TMJ Association (TMJA). Taylor MicroTechnology, Inc. 11 May 2007 <http://www.masterdocs.com/fact_sheet_files/pdf/tmj_pain.pdf >

[3] Erstad, Shannon. "Who is affected by TMJ disorders" . February 2006. 11 May 2077 <http://www.pamf.org/radonc/health/healthinfo/?A=C&type=info&hwid=hw209119§ion=hw209119-sec>

member per month (PMPM) for family coverage.[4] The information available in Maine did not allow us to perform a precise actuarial estimate of the premium impact in Maine. However, our analysis based on the statistics available allowed us to estimate a PMPM cost similar to the experience in Texas. If the mandate requires medical insurers to cover TMJ treatment, assuming the PMPM cost in the Texas analysis trended to 2006, the impact on medical premiums would be approximately 0.10%-0.20%. If the mandate required dental insurers to cover non-surgical treatments, most of the premium increase would impact only the dental premiums rather than medical. The impact on dental premiums would be approximately 1%.

Aetna does not have claims data to provide an estimate of the cost increase. Based on other studies, they estimate the premium cost impact to be approximately 1.5%, for all coverage types and population segments. Cigna estimates the additional cost of this bill to be $0.42 PMPM or 0.18% of premium regardless of plan type. Anthem Blue Cross estimates a premium impact of $0.58 PMPM or 0.26% of premium in the first year for the state employee health plan.

Delta Dental estimates that TMJ claims submitted for the state employee dental plan would increase by 1%-2% if the mandate extends to dental plans, but the impact would depend on the extent of the mandate. MetLife estimates an increase of 1% of their dental premiums, assuming 50% coinsurance and a $1,000 lifetime maximum benefit.

The magnitude of this premium increase alone would not seem sufficient to move health insurance purchasers to discontinue coverage. However, the premium increase estimated for LD 1429 when combined with large renewal increases would intensify the consumer's sensitivity to health insurance costs.

The carriers oppose adding new mandates to cover specific medical conditions because they feel it only decreases the overall affordability of health care coverage. They argue that carrier's should have the flexibility to offer a range of products with varying comprehensiveness of coverage, and employers and individuals should have the freedom to choose policies that best meet their needs.

The American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional organization, which represents more than 7,000 oral and maxillofacial surgeons in the United States, supports insurance coverage for TMJ treatments.[5]

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[4] Texas Department of Insurance, "Texas Mandated Benefit Cost and Utilization Summary Report October 2004 - September 2005 Reporting Period", <http://www.tdi.state.tx.us/reports/report3.html>

[5] American Association of Oral and Maxillofacial Surgeons,"Craniofacial Disorders Legislative Information"

II. Background

Temporomandibular joint and muscle disorders, commonly called "TMJ" or "TMD,"[6] are a group of conditions that cause pain and dysfunction in the jaw joint and the muscles that control jaw movement.[7]

Primary Symptoms Associated With TMJ Disorders:

1. Pain in the Temporomandibular (TM) Joints associated with jaw movements
2. Intermittent locking episodes
3. Limited range of vertical opening
4. Facial pain and a sense of facial muscle fatigue
5. Noises in the TM Joints associated with jaw movements (clicking, snapping, crunching, etc.)

Secondary Symptoms Associated With TMJ Disorders:

1. Earaches not associated with an infection
2. A sense of fullness in one or both ears
3. Frequent headaches
4. Ringing in the ears
5. Neck and Shoulder pain

The Joint Standing Committee on Insurance and Financial Services of the 123rd Maine Legislature (the Committee) directed the Bureau of Insurance to review LD 1429, An Act To Require Insurance Coverage for Temporomandibular Joint Disorders. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of NovaRest, Inc. and the Maine Bureau of Insurance.

The Committee also requested the analysis be based on the following amendments to the bill:

- Require that individual and group health insurance policies provide coverage for musculoskeletal disorders affecting any bone or joint in the face, neck or head if the policy would provide coverage for musculoskeletal disorders affecting other bones or joints in the body;
- Allow for coverage for appropriate medically necessary treatment referred by a physician or a dentist; and
- Exclude coverage for experimental procedures.

[6] "TMJ" is commonly used to refer both to the temporomandibular joint and to disorders of this joint. This report follows that practice. It should be clear from the context whether we are referring to the joint itself or to disorders of the joint.

[7] "TMJ Disorders". June 2006. Office of Research on Women's Health. 11 May 2007 <http://www.nidcr.nih.gov/HealthInformation/DiseasesAndConditions/TMDTMJ/TmjDisorders.htm>

The Committee's letter also asked the Bureau to provide information on the current policies and exclusions under health insurance policies and dental insurance policies regarding the treatment of temporomandibular disorders. If this mandate is enacted, the Committee wants to ensure that treatment for these disorders that is considered surgical be covered by health insurance and that treatment with certain appliances or braces are covered by dental insurance.

LD 1429 would amend sections of Maine law pertaining to individual and group health insurance plans. Appendix A includes the proposed amendments to the applicable sections of Maine law. The bill requires that health insurers and HMOs provide coverage for TMJ disorders. As currently worded the bill does not apply to dental plans because they are excluded from the definition of health insurance for purposes of mandated benefits pursuant to 24-A M.R.S.A. § 704.

The requirements of this Act would apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. For purposes of this Act, all contracts are deemed to be renewed no later than the next anniversary of the contract date.

Any policy or contract that provides coverage for TMJ may contain provisions for maximum benefits, coinsurance, reasonable limitations, deductibles, and exclusions.

From the perspective of at least one proponent, LD 1429 would put treatment of the temporomandibular joint on par with the other joints of the body. This proponent questions, "Since when did the jaw joint become a part of the body that isn't covered by insurance that covers every other bone? Why does insurance that pays for torn cartilage in the knee not pay for torn cartilage in the jaw? How can a patient with arthritis in their hips and elbows be denied coverage for the very same arthritis damage in their jaw joint?"[8]

The American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional organization, which represents more than 7,000 oral and maxillofacial surgeons in the United States, supports insurance coverage for TMJ treatments.[9]

[8] Lawrence, Martha Testimony, April 10, 2007

[9] American Association of Oral and Maxillofacial Surgeons,"Craniofacial Disorders Legislative Information"

III. Social Impact

A. Social Impact of Mandating the Benefit

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

We don't know for certain how many people have TMJ disorders, but some estimates suggest that over 10 million Americans are affected. The condition appears to be more common in women than in men.[10]

Temporomandibular joint (TMJ) disorders are most common in younger adults (ages 20 to 40) and in women. Women on hormone replacement therapy were 77% more likely to seek treatment for jaw pain.[11] Experts do not agree in their estimates of the prevalence of TMJ. One source estimates that as many as 65% to 85% of the population will develop TMJ problems at some point in their lives. In most cases, the symptoms are mild and go away without treatment. Approximately 12% of TMJ disorders become long-term (chronic) and need ongoing care.[12]

Another source reported the following estimates[13]:

Percent of population with signs	50%-75%
Percent of population with symptoms	20%-25%
Percentage of population that seeks treatment	4%

One web source estimates that 90% of all TMJ cases respond to simple, inexpensive treatments. More severe cases of TMJ dysfunction are referred to an oral surgeon who can coordinate a treatment plan that may or may not include surgery.[14]

Combining these statistics, we conclude that TMJ treatments are used by approximately 4% of

[10] NIH Publication No. 06-3487 , Revised June 2006 <www.nidcr.nih.gov>
[11] "TMJ (Temporomandibular Joint Disease/Disorders.TMJ Association (TMJA)". Taylor MicroTechnology, Inc. 11 May 2007 <http://www.masterdocs.com/fact_sheet_files/pdf/tmj_pain.pdf>
[12] Erstad, Shannon. "Who is affected by TMJ disorders" . February 2006. 11 May 2077 <http://www.pamf.org/radonc/health/healthinfo/?A=C&type=info&hwid=hw209119§ion=hw209119-sec>
[13] Davies, Dr Stephen J. "What are temporomandibular disorders?". 11 May 2007 <http://www.temporomandibular.info/intro_prevailance.html>
[14] "What is TMJ?". 2007. Cool Nurse. 11 May 2007 <http://www.coolnurse.com/tmj.htm>

the population at some time in their life and that 0.4% of the population requires one of the more extensive treatments at some point in their lives.

2. *The extent to which the service or treatment is available to the population.*

All TMJ treatments are available to the population at this time. There is a spectrum of TMJ treatments depending on the severity of the condition. The mainstay of treatment for acute TMJ pain is heat & ice, soft diet, and anti-inflammatory medications, but potential treatment may include[15]:

1. Jaw Rest: It can be beneficial to keep the teeth apart as much as possible. It is also important to recognize when tooth grinding is occurring and devise methods to cease this activity. Patients are advised to avoid chewing gum or eating hard, chewy, or crunchy foods such as raw vegetables, candy, or nuts. Foods that require opening the mouth widely, such as a big hamburger, are not recommended.

2. Heat & Ice Therapy: Assists in reducing muscle tension and spasm. However, immediately after an injury to the TMJ, treatment with cold applications is best. Cold packs can be helpful for relieving pain.

3. Medications: Anti-inflammatory medications such as aspirin, ibuprofen (Advil, and others), naproxen (Aleve, and others), or steroids can help control inflammation. Muscle relaxants, such as diazepam (Valium), aid in decreasing muscle spasms.

4. Physical Therapy: Passively opening and closing the jaw, massage, and electrical stimulation help to decrease pain and increase the range of motion and strength of the joint.

5. Stress Management: Stress support groups, psychological counseling, and medications can also assist in reducing muscle tension. Biofeedback helps patients recognize times of increased muscle activity and spasm and provides methods to help control them.

6. Occlusal Therapy: A custom made acrylic appliance which fits over the teeth is commonly prescribed for night, but may be required throughout the day. It acts to balance the bite and reduce or eliminate teeth grinding or clenching (bruxism).

7. Correction of Bite Abnormalities: Corrective dental therapy, such as orthodontics, may be required to correct an abnormal bite. Dental restorations assist in creating a more stable bite. Adjustments of bridges or crowns act to ensure proper alignment of the teeth.

8. Surgery: Surgery is indicated in those situations where medical therapy has failed. It is done as a last resort.

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[15] Shiel, Willima C. Jr., MD, FACP, FACR. "Temporomandibular Joint Disorder (TMJ)" 11 May 2007 <http://www.medicinenet.com/temporomandibular_joint__disorder/page3.htm>

TMJ arthroscopy, ligament tightening, joint restructuring, and joint replacement are considered in the most severe cases of joint damage or deterioration.

3. *The extent to which insurance coverage for this treatment is already available.*

TMJ treatment often falls in the crack between dental and medical insurance coverage. Dental coverage does not cover some treatments because they are considered medical by the dental insurer, while medical insurers may not cover treatments provided by dentists or oral surgeons. Insureds with both dental and medical coverage can find themselves in a situation where neither insurer covers the treatment for their TMJ condition.

Dental insurance typically does not cover TMJ problems except for certain simple procedures. Dental insurance is available to employees of firms that sponsor this fringe benefit. Dental insurance is also available to individual purchasers, but it is very expensive compared to group coverage. There are very significant differences in the comprehensiveness of the benefits provided under dental insurance plans provided by employers. Approximately 13% of the employers who provide dental insurance offer plans that are limited to preventative care (routine check ups and cleanings). Based on a national survey of employers, 95% of employers with 10 or more employees offer some form of dental coverage.

Anthem, Aetna and Cigna medical policies, as well as Delta Dental and MetLife dental policies do not cover TMJ therapies. Harvard Pilgrim Health Care does provide coverage.

In her April 10th testimony, Katie Fullam Harris of Anthem Blue Cross reported that[16],

> "Anthem Blue Cross and Blue Shield's policies exclude coverage for TMJ, as it is considered to be a dental-health related disease. According to our medical director, Dr. Jeff Holmstrom, treatment for TMJ is routinely provided by dentists and oral surgeons, and therefore it is most appropriately covered by dental insurance."

Harvard Pilgrim Health Care covers the following procedures for TMJ as a standard benefit:
1. Initial consultation ONLY (one consultation per lifetime, including exam and panoramic x-ray) by an oral surgeon to evaluate TMJ symptoms
2. CT scan and/or MRI when medically necessary to diagnose the cause of temporomandibular joint pathology or derangement
3. Medically necessary physical therapy for the masticatory system (subject to the member's outpatient functional therapy benefit limits)
4. Surgical treatment of TMJ when medically necessary for disorders of joint pathology, or in

situations where nonsurgical treatment has failed to relieve significant symptoms and surgical intervention is the most appropriate mode of treatment.

Harvard Pilgrim does not cover dental appliances for TMJ (including occlusal guards, night guards, splints) or dental treatment of TMJ.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

If an individual's medical or dental policy does not cover this service, they would be able to obtain the treatment, but would have to pay for it themselves. MaineCare does cover TMJ treatments on a preauthorization basis.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Assuming that an individual's health plan and dental plan did not cover the cost of TMJ treatment, the individual would have to pay the cost of the treatment.

The cost of the treatment is based on the severity of the TMJ ailment. Many self-care approaches are successful at treating TMJ. A study in the Journal of American Dental Association found that splint therapy provided no greater benefit than the self-care treatment without splint therapy.[17]

If this is not successful, a comprehensive examination and the minimum tests can cost $1,000. Sometimes patients require an MRI or other tests, which will incur additional cost. Proper splint therapy and construction could be another $1,000. After testing and initial therapy, if all that is necessary is an occlusal equilibration then there would be an additional $500 cost. Therefore, a simple case can cost around $2,500. If the patient needs a combination of treatment options, they can cost between $10,000 and $20,000. If the patient needs the most extensive surgery, the cost for the total treatment could be $50,000 or more[18]. Many families would find these costs to be a financial hardship.

6. *The level of public demand and the level of demand from providers for this treatment or service.*

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[16] Harris, Katie Fullam testimony, April 10, 2007

[17] Truelove E, et al. (2006). The efficacy of traditional, low-cost and nonsplint therapies for temporomandibular disorder. Journal of the American Dental Association, 137: 1099-1107

[18] Neer, Ronald DDS. " Valuation/Diagnosis/Treatment of TMJ Cases. 15 May 2007

The American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional organization, which represents more than 7,000 oral and maxillofacial surgeons in the United States, supports treatment for TMJ ailments. They say that, "When symptoms of TMJ trouble appear, an oral and maxillofacial surgeon should be consulted. A specialist in the areas of the mouth, teeth and jaws, the oral and maxillofacial surgeon is in a good position to correctly diagnose the problem."[19] They also indicate that, "Once TMJ disorders are correctly diagnosed, appropriate treatment can be provided."

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

The American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional organization which represents more than 7,000 oral and maxillofacial surgeons in the United States, supports insurance coverage for TMJ treatments. In their proposed model legislation, they state that:

> "The bones and joints of the face, neck, and head are subject to the same diseases, congenital deformities, and traumatic injuries as other bones and joints in the body. Many individuals suffer pain, limitation of motion and other functional defects in the head, face, and neck as a result of such maladies. A number of health insurance polices contain exclusions or limitations of coverage for procedures to treat functional defects of head, face, and neck. Such exclusions exist when the same procedures are covered in the policy if performed on other bones or joints of the body. This discrimination creates a serious gap in health care coverage for patients and can limit the treatment options available. In addition, such exclusions are not brought to the attention of plan purchasers or patients until they are denied coverage, which is generally too late for alternative action. AAOMS strongly opposes such discriminatory actions by carriers and encourages healthcare organizations to eliminate such unfair practices in their health care policies."

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

Legislation requiring coverage for TMJ procedures has been passed in 16 states. Four other states require that coverage for TMJ procedures be offered. The following grid summarized these mandates:

<http://www.expertpages.com/news/valuation_diagnosis_treatment_tmj.htm?utm_source=inc&utm_medium=articles>

[19] The American Association of Oral and Maxillofacial Surgeons, The Temporomandibular Joint (TMJ), http://www.aaoms.org/tmj.php

Mandated TMJ Coverage		
State	**Effective Year**	**Coverage**
Arkansas	2001	TMJ coverage must be offered to individuals and groups purchasing insurance policies
California	1995	Surgical procedures
Florida	1996	Medically necessary surgical procedures
Georgia	1994	Medically necessary surgical or non-surgical procedures
Illinois	1995	TMJ coverage must be offered to groups purchasing insurance policies
Kentucky	1991	Medically necessary surgical or non-surgical procedures
Maryland	1986	Medically necessary diagnostic and surgical procedures
Minnesota	1987	Medically necessary surgical or non-surgical procedures
Nevada	1989	Must provide coverage for medically necessary TMJ procedures, but may limit the coverage to 50% of UCR and exclude dental procedures.
New Mexico	1989	Medically necessary surgical or non-surgical procedures
North Carolina	1995	Medically necessary surgical or non-surgical procedures, but can exclude certain appliances
North Dakota	1989	Medically necessary surgical or non-surgical procedures
Tennessee	1997	Medically necessary surgical or non-surgical procedures
Texas	1997	Medically necessary diagnostic and surgical procedures
Utah	Ruling	Benefits should be based on the cause of the problem and the nature and appropriateness of the treatment
Vermont	1998	Medically necessary surgical or non-surgical procedures
Virginia	1995	Medically necessary diagnostic and surgical procedures
Washington	1988	TMJ coverage must be offered to groups purchasing medical or dental insurance policies
West Virginia	1998	TMJ coverage must be offered to individuals and groups purchasing insurance policies
Wisconsin	1998	Medically necessary surgical or non-surgical procedures

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

State agencies did not provide findings pertaining to the proposed legislation.

11. *Alternatives to meeting the identified need.*

This bill requires health insurers and health maintenance organizations to provide the coverage for TMJ. It is possible to require dental insurance to provide coverage for non-surgical treatments. Dental insurance is available to individuals who are employed by firms that offer dental insurance that provides comprehensive benefits. Individual dental policies are typically more expensive than coverage through an employer. Dental insurance is not as widely available as medical insurance. Furthermore, premiums for medical insurance are approximately 4-5 times those for dental insurance and therefore the extra cost for this benefit would be a much more significant percentage of the premium for dental insurance.[20] In reviewing similar laws in other states, the mandated benefit is primarily applied to medical plans. Our research uncovered only one state, Washington that placed this requirement on dental plans as well.

Dental plans have annual maximums that usually range between $1,000 -$2,000. TMJ expenses can easily meet this maximum resulting in a denial of benefits for other care such as routine and preventive dental work. A separate lifetime maximum specific to TMJ may be appropriate as well as allowing insurers the flexibility to establish deductible and coinsurance rates.

12. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

The requirements of LD 1429 are not inconsistent with the role of insurance and the concept of managed care. Most health plans currently offer coverage of surgical procedures for other joints.

13. *The impact of any social stigma attached to the benefit upon the market.*

There is little or no social stigma attached to having treatment for TMJ.

14. *The impact of this benefit upon the other benefits currently offered.*

Currently dental procedures may be covered by a dental insurance contract or by medical

[20] Mercer Foster/Higgins Survey, National Survey of Employer-sponsored Health Plans 1999

insurance contract depending on the type of service being rendered. This bill would require a medical insurance policy to provide the coverage for TMJ procedures that are provided by the type of doctors that medical insurers typically do not contract with, such as dentist.[21]

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

State legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and make self-insurance a more attractive alternative. The 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that 36% percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

Given the large annual increases in medical care costs, large employers may be particularly sensitive to any legislation that places limits on managed care and increases the cost of health care.

No information is available as to the extent to which this benefit is currently being offered by employers with self-insured plans.

16. *The impact of making the benefit applicable to the state employee health insurance program.*

Coverage is currently provided under the state employee health insurance program for the treatment of a specific organic condition of or physical trauma to the temporomandibular joint limited to surgery or injections of the TMJ, physical therapy or other medical treatments. Anthem Blue Cross estimates an additional premium impact of $0.58 per member per month (PMPM) or 0.26% of premium for coverage required by the proposed mandate in the first year for the state employee health plan. They also assumed that the number of people seeking treatment will decline in future years as many of those who have been successfully treated will not seek further treatment and the number of new cases will not supplant those already treated.

Delta Dental estimated that for the state employee dental plan TMJ claims would total $180,000 to $185,000 and premium would increase 1%-2% if the mandate were to apply to dental plans, but the impact on premium would depend on the extent of the mandate.

[21] 24-A M.R.S.A. § 2437 requires coverage of services provided by dentists if those services are within the scope of the dentist's licence and would be covered if performed by a physician. This provision is not applicable to HMOs.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

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

The impact on the cost of services from having TMJ treatments covered by insurance is not known at this time, but in general when medical services are covered by insurance it increases demand and eventually the cost of the service.

2. *The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.*

LD 1429 will increase the appropriate treatment of TMJ because the insurance coverage will allow those individuals that need more extensive treatment and cannot afford the cost of combinations of treatment options or surgery to receive it.

It is possible that LD 1429 would increase the inappropriate use of TMJ treatments. More extensive treatment may be used where it is inappropriate, since it is covered by medical insurance. Once a service is covered by insurance, there is a possibility of it being inappropriately used since the cost of its use becomes negligible to the patient.

This bill does not preclude applying a prior approval process or other utilization review procedures to minimize inappropriate usage.

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

The more extensive treatment options required by the mandate may replace the less expensive options. In some of these cases, the less expensive treatment may be appropriate, but in others, the patient would not be able to have optimum pain reduction unless more expensive combinations of treatment options or surgical procedures could be used.

4. *The methods which will be instituted to manage the utilization and costs of the proposed mandate.*

LD 1429 allows health plans to require prior authorization for TMJ treatment in the same manner that prior authorization is required for other covered diseases or conditions.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

The impact on the number of providers from having TMJ treatments covered by insurance is not known at this time, but in general when medical services are covered by insurance it increases demand and eventually the number of providers.

6. *The extent to which the insurance coverage of the health care service or providers may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

The premium impact for this bill is highly dependent on the cost sharing included in the policy. This proposed legislation would only impact the health plans that do not currently cover TMJ treatments.

In Virginia's annual report, The Financial Impact of Mandated Health Insurance Benefits and Providers for 2005, carriers reported the average percent premium impact for a similar mandate for TMJ shown in the table below.

	Individual		Group	
	Single	Family	Single	Family
HMO	0.58%	0.15%	0.24%	0.12%
Indemnity	0.34%	0.33%	0.95%	0.55%

In a study of the financial impact of a similar law in Texas, The Texas Department of Insurance estimated the cost to be approximately $0.30 PMPM for single coverage and $0.66 PMPM for family coverage.[22] The information available in Maine did not allow us to perform a precise actuarial estimate of the premium impact in Maine. However, our analysis based on the statistics available allowed us to estimate a PMPM cost similar to the experience in Texas. If the mandate requires medical insurers to cover TMJ treatment, assuming the PMPM cost in the Texas analysis trended to 2006, the impact on medical premiums would be approximately 0.10%-0.20%. If the mandate required dental insurers to cover non-surgical treatments, most of the premium increase would impact the dental premiums rather than medical. The impact on dental premiums would be approximately 1%.

Aetna does not have claims data to provide an estimate of the cost increase. Based on other

[22] Texas Department of Insurance, "Texas Mandated Benefit Cost and Utilization Summary Report October 2004 - September 2005 Reporting Period". <http://www.tdi.state.tx.us/reports/report3.html>

studies, they estimate the premium cost impact to be approximately 1.5%, for all coverage types and population segments. Cigna estimates the additional cost of this bill to be $0.42 PMPM or 0.18% of premium regardless of plan type.

Delta Dental estimates that TMJ submitted claims for the State of Maine group would increase 1%-2% of premium, but the impact on premium cannot be determined since the plan design is not known. MetLife estimates an increase of 1% of their dental premiums, if coinsurance is 50% and a lifetime max of $1,000.

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

There would not be any additional cost effect beyond benefit and administrative costs.

8. *The impact on the total cost of health care.*

Using the studies done in Texas, we conclude that that LD 1429 could increase medical premiums by 0.10%-0.20% and dental premium by 1%. Since in some cases TMJ treatments are used even if they are not covered by insurance, therefore total health care cost may increase, but by an amount less than 0.20 %.

9. *The effects of mandating the benefit on the cost of health care particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

LD 1429 would, on average, increase premiums for health plans that do not currently comply with LD 1429, by an estimated 0.10%-0.20%. Employers will pay this additional premium, as will employees to the extent the cost is passed on through the employee's contribution to the premiums. There is no reason that the estimated percentage premium increase will vary for small employers, medium-sized employers and large employers. This increase will contribute to rising premiums that may cause employers who are too small to self-insure to discontinue offering health insurance to employees. Also, many large employers are self-insured and not subject to this mandate.

This increase will contribute to rising premiums that may cause employers who are too small to self-insure to discontinue offering health insurance to employees. Fewer employees may elect

health insurance when confronted with rising premiums.

10. *The effect of the proposed mandates on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in this State.*

TMJ treatments are currently covered by MaineCare. Some individuals may have insurance and still qualify for MaineCare. These individuals may apply for MaineCare, if their insurance does not cover needed TMJ treatments, but if the treatment is covered by their insurance, the tendency may be to submit the claims to the insurer. This will shift some cost from the public to the private sector.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

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

About 12% of people who have TMJ disorders develop long-lasting (chronic) symptoms.[23] Any chronic pain or difficulty moving the jaw may affect talking, eating, and swallowing. This may affect a person's overall sense of well-being.

About 65% to 95% of people who see a doctor when they first have symptoms will get better no matter what type of treatment they get.[24]

2. *If the legislation seeks to mandate coverage of an additional class of practitioners;*

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

   LD 1429 will not require an additional class of practitioners.

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

   LD 1429 will not require an additional class of practitioners.

[23] Epker J, et al. (1999). A model for predicting TMD: Practical application in clinical settings. Journal of the American Dental Association, 130: 1470–1475
[24] Eriksson PO, Zafar H (2005). Musculoskeletal disorders in the jaw-face and neck. In RE Rakel, ET Bope, eds., Conn's Current Therapy 2005, pp. 1128–1133. Philadelphia: Elsevier Saunders.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

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

The population covered by LD 1429 is relatively small. The cost of providing TMJ treatments is estimated to be 0.10%-0.20% of the total premium for medical plans that do not currently cover this mandate. This premium increase by itself would not seem likely to move health insurance purchasers to discontinue coverage. However, average annual premium increases for health insurance have been high for employer groups. Premiums for individual medical plans have been even higher. The premium increase estimated for LD 1429 when combined with large renewal increases would intensify the consumer's sensitivity to health insurance costs.

LD 1429 may make a significant difference in the use of TMJ treatment services for the population covered. The lack of needed TMJ treatment services for this population can result in continued pain and dysfunction in the jaw joint and the muscles that control jaw movement.

The carriers oppose adding new mandates to cover specific medical conditions because they feel it only decreases the overall affordability of health care coverage. They argue that carriers should have the flexibility to offer a range of products with varying comprehensiveness of coverage, and employers and individuals should have the freedom to choose policies that best meet their needs

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

It is not practical to offer this coverage as an option for individual policyholders. It is only applicable to a relatively small segment of the population. Therefore, only this small segment would be likely to request the option, all of whom would use it, resulting in a premium that would be the more than paying for the services on an out-of-pocket basis.

3. *The cumulative impact of mandating this benefit in combination with existing mandates on costs*

and availability of coverage.

The Bureau's estimates of the premium increases due to existing mandates and the proposed mandate are displayed in Table B.

TABLE B MAXIMUM MEDICAL PREMIUM INCREASES			
	Group (more than 20 employees)	Group (20 or fewer employees)	Individuals
CURRENT MANDATES			
▪ Indemnity Plans	8.64%	4.27%	3.55%
▪ Managed Care Plans	7.51%	5.70%	3.58%
LD 1429			
▪ Fee-for-Service Plans	0.15%	0.15%	0.15%
▪ Managed Care Plans	0.15%	0.15%	0.15%
CUMULATIVE IMPACT			
▪ Fee-for-Service Plans	8.79%	4.42%	3.70%
▪ Managed Care Plans	7.66%	5.85%	3.73%

If all but surgical procedures were required to be provided by dental insurance, the impact on medical coverage would be negligible, but the premium increase for dental would be approximately 1%. This would be the first mandated benefit for dental insurance.

These increases are based on the estimated portion of claim costs that the mandated benefits represent, as detailed in Appendix B. The true cost impact is less than this for two reasons:

1. Some of these services would likely be provided even in the absence of a mandate.
2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering surgical treatments may fix a problem earlier and reduce the ongoing use of other treatments that could be used, if surgery was not an option. The cost impact is the net result of the cost of the more expensive treatment and the reduction in the utilization of less expensive treatments.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time.

VII. Appendices

Appendix A: Letter from the Committee on Insurance and Financial Services with Proposed Legislative Amendments

SENATE
NANCY B. SULLIVAN, DISTRICT 4, CHAIR
PETER B. BOWMAN, DISTRICT 1
LOIS A. SNOWE-MELLO, DISTRICT 15

COLLEEN MCCARTHY REID, LEGISLATIVE ANALYST
JAN CLARK, COMMITTEE CLERK

HOUSE
JOHN R. BRAUTIGAM, FALMOUTH, CHAIR
MARILYN E. CANAVAN, WATERVILLE
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WESLEY E. RICHARDSON, WARREN
MICHAEL A. VAUGHAN, DURHAM
JONATHAN B. MCKANE, NEWCASTLE
DAVID G. SAVAGE, FALMOUTH

STATE OF MAINE

ONE HUNDRED AND TWENTY-THIRD LEGISLATURE

COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

April 17, 2007

Marti Hooper
Senior Insurance Analyst
Life and Health Division
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Ms. Hooper:

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request the Bureau of Insurance prepare a review and evaluation of **LD 1429, An Act to Require Insurance Coverage for Temporomandibular Joint Disorders.**

A copy of the bill is enclosed. After the public hearing, the committee identified several areas of clarification needed in the bill as drafted. We ask that the Bureau prepare its review and evaluation based on the following amendments to the bill:

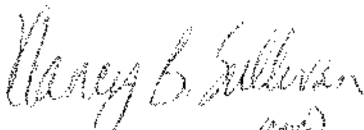
- Require that individual and group health insurance policies provide coverage for musculoskeletal disorders affecting any bone or joint in the face, neck or head if the policy would provide coverage for musculoskeletal disorders affecting other bones or joints in the body;
- Allow for coverage for appropriate medically necessary treatment referred by a physician or a dentist; and
- Exclude coverage for experimental procedures.

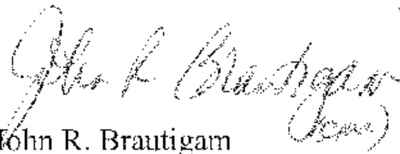
The committee also recognizes that there may be tension between the responsibility of health insurance and dental insurance if such a mandate is enacted. To the extent possible, we ask that the Bureau provide information on the current policies and

exclusions under health insurance policies and dental insurance policies regarding the treatment of temporomandibular disorders. If this mandate proposal is enacted, the committee wants to ensure that treatment for these disorders that is considered surgical be covered by health insurance and that treatment with certain appliances or braces be covered by dental insurance.

Please prepare the evaluation using the guidelines set out in Title 24-A § 2752 and submit the report to the committee within 8 weeks so the committee can take final action on LD 1429 before adjournment of the First Regular Session. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,





Nancy B. Sullivan
Senate Chair

John R. Brautigam
House Chair

cc: Members, Insurance and Financial Services Committee

123rd MAINE LEGISLATURE

FIRST REGULAR SESSION-2007

Legislative Document	**No. 1429**
H.P. 1003	House of Representatives, March 15, 2007

An Act To Require Insurance Coverage for Temporomandibular Joint Disorders

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Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

Millicent M. MacFarland
MILLICENT M. MacFARLAND
Clerk

Presented by Representative VAUGHAN of Durham.
Cosponsored by Senator SULLIVAN of York and
Representatives: BRAUTIGAM of Falmouth, CANAVAN of Waterville, CONOVER of Oakland, CROCKETT of Augusta, RICHARDSON of Warren, SAVAGE of Falmouth, Senators: MARRAC of Kennebec, SNOWE-MELLO of Androscoggin.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2317-B, sub-§12-B is enacted to read:

12-B. Title 24-A, sections 2762, 2847-M and 4253. Coverage for temporomandibular joint disorders, Title 24-A, sections 2762, 2847-M and 4253;

Sec. 2. 24-A MRSA §2762 is enacted to read:

§ 2762. Coverage for temporomandibular joint disorders

1. Required coverage. All individual health insurance policies and contracts must provide coverage for temporomandibular joint disorders.

2. Limits; coinsurance; deductibles. Any policy or contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

Sec. 3. 24-A MRSA §2847-M is enacted to read:

§ 2847-M. Coverage for temporomandibular joint disorders

1. Required coverage. All group health insurance policies, contracts and certificates must provide coverage for temporomandibular joint disorders.

2. Limits; coinsurance; deductibles. Any policy, contract or certificate that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

Sec. 4. 24-A MRSA §4253 is enacted to read:

§ 4253. Coverage for temporomandibular joint disorders

1. Required coverage. All health maintenance organization individual and group health insurance policies, contracts and certificates must provide coverage for the purchase of temporomandibular joint disorders.

2. Limits; coinsurance; deductibles. Any policy, contract or certificate that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

Sec. 5. Application. The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. For purposes of this Act, all contracts are deemed to be renewed no later than the next anniversary of the contract date.

1 **SUMMARY**

2 This bill requires health insurance policies, contracts and certificates to provide coverage for
3 temporomandibular joint disorders. The provisions of this bill apply to all policies, contracts and
4 certificates issued or renewed on or after January 1, 2008.

Appendix B: Cumulative Impact of Mandates

Cumulative Impact of Mandates in Maine

Following are the estimated claim costs for the existing mandates:

- ***Mental Health*** (Enacted 1983) – The mandate applies only to group plans. It applies to all group HMO plans but does not apply to employee group indemnity plans covering 20 or fewer employees. Mental health parity for listed conditions was effective 7/1/96 but does not apply to any employer with 20 or fewer employees, whether under HMO or indemnity coverage. The list of conditions for which parity is required was expanded effective 10/1/03. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. The percentage had remained in the 3.27% to 3.47% range from 1998 to 2002 but has decreased since then, reaching 2.90% in 2005. For 2005, this broke down as 2.62% for HMOs and 3.49% for indemnity plans. This decrease occurred despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. Either the expansion has had no impact or the impact was offset by other factors such as the continuing shift from inpatient care to outpatient care. We estimate a continuation of 2005 levels going forward. For HMO plans covering employers with 20 or fewer employees, we use half the value for larger groups to reflect the fact that parity does not apply. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while groups of 20 or fewer are exempt from the parity requirement in the case of HMO coverage and from the entire mandate in the case of indemnity coverage.

- ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as indemnity carriers. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31%. It then increased and leveled off at a range of 0.59% to 0.67% for 2002 through 2005 despite implementation of the parity requirement. The long-term decrease was probably due to utilization review, which sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 and leveled off at about 55% for 1999-2005. The 0.67% for 2005 broke down as 0.55% for HMOs and 0.93% for indemnity plans. We estimate substance abuse benefits to remain at the current levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how

much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while the mandate applies only to groups larger than 20.

- ***Chiropractic*** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to a high of 1.51% in 2000. Since then, it has decreased slightly to between 1.32% and 1.46% during 2001 to 2005. The level varies significantly between group and individual. The variation between HMOs and indemnity plans has decreased to an insignificant level. For 2005, the percentages for group plans were 1.46% for HMO plans and 1.30% for indemnity plans with an aggregate of 1.41%. For individual plans, it was 0.33% for HMO plans, and 0.71% for indemnity plans with an aggregate of 0.70%. We estimate the aggregate levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Screening Mammography*** (Enacted 1990) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.7% in 2002, decreasing slightly to 0.69% in 2005, which may reflect increasing utilization of this service followed by a leveling off. This figure broke down as 0.70% for HMO plans, 0.67% for indemnity plans. We estimate 0.69% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Dentists*** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995) – At the time this mandate was being considered in

1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003) – This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20 and 0.08% for small employer groups and individuals.

- ***LCPCs*** (Enacted 2003) – This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- Licensed Pastoral Counselors and Marriage & Family Therapists (Enacted 2005) – This mandate requires coverage of **licensed pastoral counselors and marriage & family**

therapists. Our report indicated no measurable cost impact for this coverage.

These costs are summarized in the following table.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[1]	0[1]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.10%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[1]	--
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups of more than 20	0.93%	0.55%
1975 1983 1995 2003	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	3.49%	2.62%
		Groups of 20 or fewer	--	1.31%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.41%	1.41%
		Individual	0.70%	0.70%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.69%	0.69%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Prenatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.20%	0.20%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	0.01%	0

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.10%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%	0.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%	0.30%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	0.07%	0
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	--	0.16%
1999	Prescription drug must include **contraceptives.**	All Contracts	0.80%	0.80%
1999	Coverage for **registered nurse first assistants**.	All Contracts	0	0
2000	Access to **clinical trials**.	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs**.	All Managed Care Contracts	0	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	0.03%	0.03%
		All other	0.08%	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0	0
	Total cost for groups larger than 20:		**8.64%**	**7.51%**
	Total cost for groups of 20 or fewer:		**4.27%**	**5.70%**
	Total cost for individual contracts:		**3.55%**	**3.58%**

Appendix C: Scope of Similar Laws in Other States

NAIC Summary

AR
(8/06) § 23-79-150 Carriers must offer optional coverage for musculoskeletal disorders affecting the face, head or neck, including TMJ. Coverage shall be the same as provided for any other musculoskeletal disorder.
CA
(8/06) Ins. § 10123.21 Individual and group policies must provide coverage for conditions directly affecting the upper or lower jawbone or associated bone joints.
CT
(8/06) Bulletin HC-47 TMJ treated as any other illness or injury and must be covered, whether surgical or non-surgical.

FL
(8/06) §§ 627.65735; 641.31094 Group policies that provide coverage for any diagnostic or surgical procedure involving bones or joints may not discriminate for similar care for bones or joints of the jaw and facial region.
GA
(8/06) §§ 33-29-20; 33-30-14 No policy may exclude surgical or nonsurgical treatment to correct TMJ by physicians or dentists.

HI
(8/06) § 431:10A-116 Covers treatment for accidental injury to jaw.

IL
(8/06) 215 ILCS 5/356q Group accident and health policies with hospital, medical or surgical treatment coverage shall offer reasonable and necessary medical treatment of TMJ and craniomandibular disorders. Maximum lifetime benefit is not to be lower than $2,500.
KY
(8/06) §§ 304.17-319; 304.18-0365; 304.32-1585;
304.38-1937 If cover skeletal disorders, must cover TMJ disorders.

MN
(8/06) § 62A.043 Policies other than specified disease policies must specifically provide coverage for surgical and nonsurgical treatment of TMJ and craniomandibular disorder.
MS
(8/06) § 83-9-45 Must offer coverage for diagnostic and surgical treatment of TMJ and craniomandibular disorder, same level as for any other joint in the body. Can be administered by physician or dentist.

NE
(8/06) § 44-789 Must offer coverage for surgical and nonsurgical treatment of bone or joint of face, neck or head.

NV
(8/06) §§ 689A.0465; 689B.0739; 695B.1931; 695C.1755 Health policy shall cover the temporomandibular joint up to specified limits. Can exclude methods of treatment recognized as dental procedures, including the extraction of teeth.
NM
(8/06) § 59A-16-13.1 Policies other than specified disease policies must specifically provide coverage for

surgical and nonsurgical treatment of TMJ and craniomandibular disorder. Not required to cover orthodontic appliances unless disorder is related to trauma.
NC
(8/06) § 58-3-121 If pay for any procedures involving bones or joints, may not exclude same coverage for procedures involving bones and joints of face. Coverage to TMJ must include splinting and use of intraoral prosthetic devices subject to maximum limits.
ND
(8/06) § 26.1-36-09.3 Mandates coverage for surgical and nonsurgical treatment of TMJ and craniomandibular disorder; $10,000 maximum for surgery, $2500 maximum for non-surgical treatment.
TX
(8/06) I.C. Sec. 1360.004 If provide coverage for treatment of skeletal joints, provide comparable benefits for TMJ if medically necessary as a result of accident, trauma, congenital defect, developmental defect, or a pathology.
UT
(8/06) Bulletin 90-3 Department finds that benefits be based on the cause of the problem and the nature and appropriateness of the treatment. Insurers may not systematically deny coverage by classifying treatment as either "dental" in a medical policy or "medical" in a dental policy.
VT
(8/06) tit. 8 § 4089g

Bulletin 63 Cover diagnosis and treatment for a musculoskelatal disorder that affects any bone or joint in the face, neck or head if caused by an accident, trauma, congenital defect, developmental defect, or a pathology. May be administered by a physician or a dentist.

All insurers writing health insurance will honor claims for treatment of temporamindibular joint syndrome.
VA
(8/06) § 38.2-3418.2 If provide coverage for treatment of skeletal joints, provide comparable benefits for TMJ.
WA
(8/06) §§ 48.21.320; 48.44.460; 48.46.530 Must offer coverage for TMJ disorders. Insurers may not systematically deny coverage by classifying treatment as either "dental" in a medical policy or "medical" in a dental policy.
WI
(8/06) § 632.895 (11) If offer coverage for diagnostic or surgical procedure involving bone, joint, tissue or muscle, required coverage for surgical and nonsurgical treatment of TMJ disorders, if condition is caused by congenital, developmental or acquired deformity, disease or injury.
WV
(8/06) § 33-16-3f ; Reg. 114-29 Mandated offering of coverage for temporomandibular disorders and craniomandibular disorders. May decline coverage by written waiver.

Appendix D: References

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Appendix E: Aetna Response Letter

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May 21, 2007

Ms. Marti Hooper, CEBS
Actuarial Assistant
Maine Bureau of Insurance
Gardiner Annex
124 Northern Avenue
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**Subject: An Aetna Response to a Request for Information
Mandated Benefit Report for LD 1429**

Dear Ms. Hooper:

This letter is in response to your request for information for LD 1429, "An Act To Require Insurance Coverage for Temporomandibular Joint Disorders". This mandate would require coverage provided for musculoskeletal disorders affecting any bone or joint in the face, neck, or head if the policy would provide coverage for musculoskeletal disorders affecting other bones or joints in the body. This would include coverage for appropriate medically necessary treatment referred by a physician or dentist, but exclude coverage for experimental procedures.

Aetna standardly excludes coverage for treatment of temporomandibular disorders (TMD) and temporomandibular joint disfunction (TMJ). However, where TMD and TMJ are covered (typically self-insured programs), requests for surgery require review by Aetna's Oral and Maxillofacial Surgery patient management unit. Reviews must include submission of a problem-specific history (i.e., Aetna Temporomandibular Disorder Questionnaire) and physical examination, TMJ radiographs / diagnostic imaging reports, patient records reflecting a complete history of 3 to 6 months of non-surgical management (describing the nature of the non-surgical treatment, the results, and the specific findings associated with that treatment), and the proposed treatment plan. Coverage decisions are determined after review of all

pertinent data.

The background for Aetna's coverage decision is as follows:

Although the precise etiology of temporomandibular joint syndrome and temporomandibular joint disorder has not yet been identified, these conditions are believed to be the result of either "macro" or "micro" trauma affecting the joint and/or the associated facial musculature. Macro-trauma is usually historically obvious (e.g., acute joint overload), and there is generally a documented history of direct trauma to the TMJ. Micro-trauma is a chronic and insidious process, multi-factorial in presentation, and commonly associated with parafunctional habits, stress and anxiety, sleep disorders, dysfunctional occlusion, and various myofascial conditions (e.g., fibromyalgia).

The diagnosis of TMD is largely based upon the symptoms of pain and signs of TMD (e.g. joint sounds, variations from ideal disc position, clicking). These signs may also be found in large segments of the general population without evidence of impairment or dysfunction. According to available literature, specialized radiological studies (e.g., cephalometric x-rays, tomograms, submental vertex radiographs, MRI or CT scans) are not medically necessary in evaluating persons with TMD unless surgery is being considered.

Therapy of TMD varies considerably according to the particular training, discipline and experience of the clinician. This variation in clinical practice is due, in part, to a paucity of evidence-based outcome research and lack of consensus on the appropriate management of TMD. Scientifically valid clinical trials are lacking for the vast majority of therapies that are currently employed. There are also no objective, generally accepted, diagnostic standards to correctly identify when a TMD is present. The appropriate diagnosis and treatment of TMD is complicated by a high incidence of TMD/TMJ signs and symptoms that are associated with systemic disorders. These usually represent local or regional manifestations of chronic, global, musculoskeletal pain conditions, such as fibromyalgia, systemic myofascial pain and chronic fatigue syndrome. While an association with headaches has been identified, a causal relationship between TMD/TMJ and headaches has not been established. These conditions occur coincidentally and may be produced by etiologic factors that are common to both.

The National Institutes of Health emphasizes the importance of two key words in therapy: *CONSERVATIVE & REVERSIBLE.* A growing body of literature supports non-surgical intervention for this condition. Similar to other musculoskeletal/joint conditions, treatment is directed towards unloading the affected structures and managing the attendant discomfort. Non-surgical therapy customarily includes occlusal appliance therapy, physical therapy, medical management, and relaxation/cognitive-behavioral therapy. Prudence usually dictates that non-surgical therapy first be exhausted prior to any invasive therapies. Patients with a long history of head and neck pain may be candidates for a chronic pain assessment. Controlled studies are important because, according to an NIH Consensus Conference, up to 90 percent of TMJ patients symptoms resolve spontaneously.

In cases involving chronic intractable pain and/or prior (including multiple) TMJ surgical procedures, caution is recommended due to the significant morbidity that may be experienced with TMJ surgical interventions. The long-term prognosis of this therapy for intractable pain may be unfavorable, due to the neurophysiology of chronic pain disorders. There is also evidence that the prognosis for success decreases with each additional (repeat) TMJ surgical intervention. In such cases, the literature indicates that the most promising treatment may be admission into a multidisciplinary chronic pain treatment program.

For persons who already have had implant or other invasive surgery, additional surgical interventions (with the possible exception of implant removal) should be considered only with great caution, since the evidence indicates that the probability of success decreases with each additional surgical intervention. For these persons, available evidence indicates that the most promising immediately available treatment may be a patient-centered, multidisciplinary, palliative approach.

Attached at the end of this document is a listing of codes outlining those services which Aetna typically covers, does not cover, and considers experimental.

As Aetna does not currently cover the benefit as outlined in LD 1429, we do not have claims data to provide. However, based upon national results and actuarial studies, we estimate the premium cost impact to be approximately 1.5%, depending on the underlying cost-sharing structure of a benefit plan. This applies to all coverage types and population segments.

As with any benefit mandate, there would also be a slight increase in overall administrative costs due to manual intervention required for claims administration and training necessary to educate Aetna's claim and customer service personnel on the specifics of the benefit mandate and how it differs from Aetna's standard policy.

Ms. Hooper, I hope this answers your questions satisfactorily. Please feel free to contact me if you have any questions. I can be reached at the phone number above, or via email at JukeJN@aetna.com.

Sincerely,

Jennifer N. Juke
Actuarial Team Lead
Small Group Actuarial, Northeast
Aetna Inc.

c. Barbara Hennessy, Regional Counsel

CPT Codes / HCPCS Codes / ICD-9 Codes

SECTION 1: Codes covered if selection criteria are met:

CPT CODES:

20552	Injection(s); tendon sheath, ligament, single or multiple trigger point(s), one or two muscles
20553	single or multiple trigger point(s), three or more muscles
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
21010	Arthrotomy
21050	Condylectomy, TMJ
21060	Meniscectomy, TMJ
21070	Coronoidectomy (separate procedure)
21076	Impression and custom preparation; surgical obturator prosthesis
21079	interim obturator prosthesis
21080	definitive obturator prosthesis
21081	mandibular resection prosthesis
21082	palatal augmentation prosthesis
21083	palatal lift prosthesis
21085	oral surgical splint
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21240	Arthroplasty, TMJ, with or without autograft
21242	Arthroplasty, TMJ, with allograft
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21440	Closed treatment of mandibular, or maxillary alveolar ridge fracture (separate procedure)
21445	Open treatment of mandibular, or maxillary alveolar ridge fracture (separate procedure)
21450	Closed treatment of mandibular fracture; without manipulation

21451	with manipulation
21452	Percutaneous treatment of mandibular fracture; with external fixation
21453	Closed treatment of mandibular fracture with interdental fixation
21454	Open treatment of mandibular fracture with external fixation
21461	Open treatment of mandibular fracture without interdental fixation
21462	with interdental fixation
21465	Open treatment of mandibular condylar fracture
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21480	Closed treatment of temporomandibular dislocation; initial or subsequent
21485	complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490	Open treatment of temporomandibular dislocation
21497	Interdental wiring, for condition other than fracture
29800	Arthroscopy, TMJ; diagnostic
29804	Arthroscopy, TMJ; surgical
90901	Biofeedback training by any modality
97010	Application of a modality to one or more areas; hot or cold packs
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97810 - 97814	Acupuncture, 1 or more needles

HCPCS CODES:

D0320	Temporomandibular joint arthrogram, including injection
D0321	Other temporomandibular joint films, by report
D0322	Tomographic survey
D0340	Cephalometric film
D5931 - D5936, D5954 - D5982	Maxillofacial prosthetics
D5988	Surgical splint
D7630	Mandible-open reduction (teeth immobilized, if present)
D7640	Mandible-closed reduction (teeth immobilized, if present)
D7730	Mandible-open reduction
D7740	Mandible-closed reduction
D7810 - D7880	Reduction of dislocation and management of other temporomandibular joint dysfunctions
E0746	Electromyography (EMG), biofeedback device

ICD-9 CODES:

524.60 - 524.69	Temporomandibular disorders
802.20 - 802.5	Fracture of mandible, closed or open, or malar and maxillary bones closed
830.0 - 830.1	Dislocation of jaw, closed or open
996.77	Other complications due to internal joint prosthesis
996.78	Other complications due to other internal orthopedic device, implant, and graft

SECTION 2: Codes covered NOT COVERED:

CPT CODES:

21120 - 21123	Genioplasty
21125 - 21127	Augmentation mandibular body or angle
21141 - 21147	Reconstruction midface, Lefort I
21150 - 21151	Reconstruction midface, Lefort II
21154 - 21155	Reconstruction midface, Lefort III (extracranial), any type, requiring bone grafts (includes obtaining autografts)

Code	Description
21159 - 21160	Reconstruction midface, Lefort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts)
21193 - 21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy
21195 - 21196	Reconstruction of mandibular rami and/or body, sagittal split
21198 - 21199	Osteotomy, mandible, segmental;
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)
21208 - 21209	Osteoplasty, facial bones
21243	Arthroplasty, TMJ, with prosthetic joint replacement
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)
21248 - 21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder)
70487	Computerized tomography, maxillofacial area; with contrast material
70488	without contrast material, followed by contrast material(s) and further sections
76101	Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than urography; unilateral
76102	bilateral
93760	Thermogram; cephalic
93875	Non-invasive physiologic studies of extracranial arteries, complete bilateral study (e.g., periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral
95868	cranial nerve supplied muscles, bilateral
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve any one method
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97020	microwave (deleted 12-31-05)
97024	Diathermy (e.g., microwave)
97026	infrared
97028	ultraviolet

97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	iontophoresis; each 15 minutes
97035	ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes

HCPCS CODES:

A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)
D0350	Oral/facial photographic images
D5110 - D5899	Prosthodontics (removable)
D6210 - D6999	Prosthodontics
D7899	Unspecified TMD therapy, by report
D7940 - D7955	Osteoplasty-for orthognathic deformities, osteotomy-mandibular rami, with bone graft; includes obtaining the graft, segmented or subapical-per sextant or quadrant, body of mandible, Lefort I, Lefort II, Lefort III with or without bone graft, osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones-autogenous or nonautogenous, or repair of maxillofacial soft and hard tissue defect
D9940	Occlusal guard, by report
D9951	Occlusal adjustment - limited
D9952	Occlusal adjustment - complete
E0720	TENS, two lead, localized stimulation
E0730	Transcutaneous electrical nerve stimulation device, four or more leads, for multiple nerve stimulation
E0745	Neuromuscular stimulator, electronic shock unit

SECTION 3: Services considered experiemental and investigational for diagnosis and treatment of TMJ disorders:

1. Diagnostic procedures

1. Muscle testing / range of motion measurements (incidental to exam)
2. Cephalometric or lateral skull x-rays
3. Electromyography (EMG), surface EMG Electronic registration (Myomonitor)
4. Neuromuscular junction testing, somatosensory testing
5. Standard dental radiographic procedures
6. Sonogram (ultrasonic Doppler auscultation)
7. Computerized mandibular scan / kinesiography / electrogathograph / jaw tracking
8. Thermography
9. Diagnostic study models.

2. Non-surgical treatments

    1. Prophylactic management of TMJ disorder, including occlusal adjustment
    2. Cranial (craniosacral) manipulationContinuous passive motion
    3. Radiofrequency generator thermolysis
    4. Orthodontic / bite adjustment services
    5. Dental restorations / prostheses
    6. Diathermy, infrared, and ultrasound treatments
    7. Low level (cold) laser
    8. Hydrotherapy (immersion therapy, whirlpool baths)
    9. Myomonitor treatment (J-4, BNS-40, Bio-TENS)
    10. Myofunctional therapy
    11. Therabite Jaw Motion Rehabilitation System
    12. Iontophoresis
    13. Irreversible occlusion therapy aimed at modification of the occlusion itself through alteration of the tooth structure or jaw position
    14. Neuromuscular re-education
    15. Transcutaneous electrical nerve stimulation (TENS)
    16. Botulinum toxin (type A or type B)

3. Surgical treatments

    1. Christensen total TMJ prosthesis
    2. Modified condylotomy or intra-oral vertical ramus osteotomy when submitted with a diagnosis of internal derangement of the TMJ
    3. Treatment of alveolar cavitational osteopathosis
    4. Partial TMJ prostheses.
    5. Orthognathic surgery