REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

SENATE BILL 553 (1994): MANDATED COVERAGE FOR DIAGNOSTIC AND SURGICAL PROCEDURES INVOLVING BONES AND JOINTS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 8

COMMONWEALTH OF VIRGINIA
RICHMOND
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October 21, 1994

To: The Honorable George Allen
Governor of Virginia
and
The General Assembly of Virginia

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

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of Senate Bill 553 (1994 Session) regarding a proposed mandated benefit for diagnostic and surgical procedures involving bones and joints.

Respectfully submitted,

Clarence A. Holland
Chairman
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INTRODUCTION

During the 1994 Session of the General Assembly, the Senate Committee on Commerce and Labor referred Senate Bill 553 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) for review. Senate Bill 553 is patroned by Senator Benjamin J. Lambert, III.

The Advisory Commission held a hearing on April 18, 1994 in Richmond to receive public comment on Senate Bill 553. Eight speakers addressed the proposal. Three representatives of the Virginia Dental Association and the Virginia Society of Oral and Maxillofacial Surgeons, a pediatric rheumatologist from Children's Hospital in Richmond, and two concerned citizens that had been treated for diseases affecting facial bones or joints spoke in favor of the bill. Representatives of Trigon Blue Cross and Blue Shield (Trigon) and the Virginia Association of Health Maintenance Organizations spoke in opposition to the measure. In addition, the Virginia Farm Bureau Federation filed written comments opposing Senate Bill 553. The Advisory Commission concluded its review of Senate Bill 553 on June 28, 1994.

SUMMARY OF PROPOSED LEGISLATION

Senate Bill 553 requires insurers, health services plans, and health maintenance organizations to provide coverage for diagnostic and surgical procedures involving <u>any</u> bone or joint of the skeletal structure including any bone or joint of the head, neck, face or jaw. The bill only requires coverage for procedures that are performed because of a medical condition or injury which prevents normal function of the joint or bone and are deemed medically necessary to restore or maintain functional capacity of the affected part.

Unlike most mandated benefit statutes, this proposal would apply to Medicare supplement policies. Currently, Medicare supplement policies must conform to standards established by the federal government. Any state requirement would likely be superseded by federal law. In addition, the bill does not include language to exclude short-term travel, accident-only, limited or specified disease policies, or short-term nonrenewable policies of not more than six months' duration from its requirements. Historically, such policies have been exempt from mandated benefit requirements in Virginia.

Proponents of Senate Bill 553 contend that the measure is needed because some insurers exclude coverage for the treatment of diseases of the facial bones and joints while providing coverage for identical or similar treatment of those diseases affecting bones and joints anywhere else in the body. They argue that all bones and joints are susceptible to the same diseases and that the location of the bone or joint should not have any bearing on whether a procedure is covered or not. Proponents stated that the bill does not require coverage for the treatment of dental, orthodontic or non-functional cosmetic problems.

As an example, proponents described a situation where a patient is diagnosed with juvenile arthritis or Still's disease and has joints throughout his body which are affected. In such a case some insurers cover the treatment of every joint except the temporomandibular joint (TMJ).

Opponents contend that any new mandated benefit will increase the cost of health insurance coverage and unfairly burden small employers and individuals that are often the least able to absorb premium increases. One insurer has stated that the coverage in question is already available in the marketplace and that insurers need to be able to impose medical necessity and other reasonable requirements for making coverage decisions. Concern was also expressed that distinctions between medical and dental care and coverage need to be maintained.

CURRENT INDUSTRY PRACTICES

The State Corporation Commission Bureau of Insurance (Bureau) surveyed 50 of the top writers of accident and sickness insurance in Virginia (insurers, health services plans, and HMOs) regarding Senate Bill 553. Thirty-two companies responded by April 14, 1994. Three of those indicated that they have little or no applicable health insurance business in force in Virginia and, therefore, could not provide the information requested. Of the 29 respondents that completed the survey, 22 (76%) reported that they currently provide the coverage required by Senate Bill 553 to their Virginia policyholders. Some respondents did note, however, that higher copayments or other limitations are often imposed on coverage for the treatment of temporomandibular joint (TMJ) disorders.

Trigon reported that the estimated average cost for services associated with a TMJ disorder case is $2,000. The company also reported that in 1993 it provided coverage for slightly more than 1,000 such cases. Trigon has reported that it has been unable to determine the impact on premiums for the proposed mandated coverage because the bill includes all services for bone and joint conditions. However, the company estimated that current coverage for the treatment of TMJ syndrome impacts premiums by less than one-tenth of one percent.

Most respondents to the Bureau's survey provided cost figures between $0.18 and $2.50 per month per policyholder or group certificate holder. These cost estimates appear to represent only the cost of coverage for the treatment of bones and joints of the head, neck, face and jaw areas.

A representative of the Virginia Association of HMOs stated that HMOs often exclude coverage for the treatment of TMJ syndrome. It was emphasized that HMOs are concerned primarily with disease prevention and the management of acute conditions rather than the management of chronic pain conditions. It was stated that HMOs typically do cover those services which are medically necessary in the treatment of bone and joint disorders.

TMJ SYNDROME

TMJ syndrome refers to a variety of conditions that involve pain and discomfort in the temporomandibular area. Unfortunately, there is no universally accepted treatment protocol for the variety of conditions that are referred to as TMJ syndrome. One proponent likened this syndrome to lower back pain and whiplash with respect to the lack of one superior mode of treatment. Proponents explained that often there is a muscular component to the problem.

Proponents noted that Senate Bill 553 is purposely limited to diagnostic and surgical procedures in an effort to avoid the problems of mandating coverage for the treatment of every condition affecting the TMJ. They contend that they are aware of the problems facing insurers regarding such a mandate. They have stated that their goal is to assure that those patients with documented diseases affecting their facial bones or joints, such as arthritis or disc problems, which affect the function of the jaw are not adversely affected by insurer attempts to control claims associated with TMJ syndrome. They also emphasize that coverage is being denied for surgical procedures on bones and joints other than the TMJ and, therefore, the bill is worded to include all bones and joints of the head, neck, face, and jaw.

SIMILAR LEGISLATION IN OTHER STATES

According to information published by the National Association of Insurance Commissioners, ten states currently require coverage of expenses associated with TMJ disorders or conditions affecting any facial bone or joint. Another three states require that such coverage be offered to policyholders. Senate Bill 553 is not limited to conditions affecting the TMJ.

Mandated Coverage	Mandated Offer
Arkansas	Mississippi
Georgia	Washington
Kentucky	West Virginia
Minnesota	
Nevada	
New Mexico	
North Carolina	
North Dakota	
Texas	
Vermont	

REVIEW CRITERIA

SOCIAL IMPACT

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

One proponent cited statistics supplied by the American Society of Oral and Maxillofacial Surgeons that indicate that on average between 125 and 150 TMJ surgical procedures are performed annually in Virginia. Trigon reported slightly more than 1,000 cases in which the company covered services for TMJ syndrome in 1993 (not limited to surgical procedures).

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

Of the 29 respondents to the Bureau's insurer survey, 22 (76%) reported that they currently provide the coverage required by Senate Bill 553 to their Virginia policyholders. One proponent indicated that Trigon provides the level of coverage sought by the supporters of Senate Bill 553.

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

Coverage is generally available; however, inconsistencies among insurers leaves some insureds without coverage. One proponent explained that her insurer had paid nearly $100,000 for a total of nine surgical procedures since 1976. She indicated that an acquaintance with the same condition cannot afford to undergo surgical treatment because her insurer does not cover the procedure and she does not have the necessary financial resources otherwise.

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

Coverage is generally available; however, inconsistencies among insurers leaves some policyholders without coverage. The case cited under the criterion listed above is one example.

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

It has been reported that the American Society of Oral and Maxillofacial Surgeons estimates that on average between 125 and 150 TMJ surgical procedures are performed annually in Virginia. Trigon reported slightly more than 1,000 cases in which the company covered services (not limited to surgical procedures) for TMJ syndrome in 1993.

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

The level of public demand for this coverage is unknown. As with many health insurance benefits, it is accepted that many policyholders are not knowledgeable about the specific terms of their coverage until they are diagnosed with a disease that requires a specific treatment.

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

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

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

The Advisory Commission is not aware of any such findings of a state health planning agency or appropriate health system agency relating to the social impact of this proposal.

FINANCIAL IMPACT

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

No information was provided by either proponents or opponents that would suggest that enactment of this bill would either increase or decrease the cost of treatment for facial bones and joints over the next five years.

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

Proponents stated that some patients do not undergo treatment because of its cost. They contend that some insurers exclude such coverage without regard to medical necessity. No information was provided regarding a possible increase in the inappropriate use of such treatment.

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

The range of services covered by this bill were not identified as substitutes for more or less expensive treatments of the same conditions.

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

It is unlikely that the proposed coverage would significantly affect the number and types of providers of the mandated treatments because it is apparent that many insurers already provide such coverage and because the number of insureds needing such treatment is relatively small.

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

It is unlikely that this proposed coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expense of policyholders because it would apply to all policyholders equally and is not likely to result in a significant increase in claim submissions because of its limited scope.

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

The impact on the total cost of health care is not expected to be significant.

MEDICAL EFFICACY

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

Opponents did not challenge the medical efficacy of diagnostic and surgical treatments of the facial bones and joints.

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

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

Not applicable.

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

Not applicable.

EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY CONSIDERATIONS

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

Senate Bill 553 addresses a medical need to surgically treat certain conditions affecting bones and joints of the face. The coverage is consistent with the role of health insurance.

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

The cost of the mandated coverage has been estimated to be very low. Trigon estimates that less than one-tenth of one percent of premiums is attributable to claims involving TMJ syndrome. Insurers responding to a Bureau survey projected monthly premium costs in the range of $0.18 to $2.50 per individual policyholder or group certificate holder to comply with Senate Bill 553.

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

The cost of a mandated offer of coverage would be expected to be higher due to adverse selection by those who had reason to believe they might need such treatment in the future. In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insureds. Therefore, it is possible that many insureds would not benefit from such a requirement.

RECOMMENDATION

The Advisory Commission supports the objective of requiring coverage for the medical and surgical treatment of bones and joints of the head, neck, face, and jaw when the same or similar treatment is covered if the identical condition affects a bone or joint in another part of the body. Coverage for dental and cosmetic services should not be required. The Advisory Commission voted unanimously (7-Yes, 0-No) on June 28, 1994 to adopt this position.

This recommendation supports the intent of Senate Bill 553 as presented by those proponents that provided comments to the Advisory Commission during its review process. The Advisory Commission does not endorse the language proposed in Senate Bill 553 because it is uncertain that it adequately reflects the stated intent of the bill. It is concerned that certain medically necessary services may not be covered if the current language is adopted. Also, the bill is inconsistent with other mandated benefit statutes in that it applies to Medicare supplement, short-term travel, accident-only, limited or specified disease policies, and short-term nonrenewable policies of not more than six months' duration.

CONCLUSION

Some insurers have chosen to exclude from coverage the treatment of conditions affecting the bones and joints of the head, neck, face and jaw even though they provide coverage for the same or similar treatment of the those conditions when they affect other parts of the skeletal structure. Information provided to the Advisory Commission during the course of its review indicates that the financial impact of mandating this coverage would not be significant. The potential financial impact is limited because many insurers already provide such coverage and because associated claims costs are relatively low.

LD1042673

1 SENATE BILL NO. 553
2 Offered January 25, 1994
3 *A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code*
4 *of Virginia by adding a section numbered 38.2-3418.2, relating to accident and sickness*
5 *insurance; coverage of procedures involving bones and joints.*
6
7 Patrons—Lambert, Howell and Miller, Y.B.; Delegates: DeBoer, Jones, D.C. and Melvin
8
9 Referred to the Committee on Commerce and Labor
10
11 Be it enacted by the General Assembly of Virginia:
12 1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of
13 Virginia is amended by adding a section numbered 38.2-3418.2 as follows:
14 *§ 38.2-3418.2. Coverage of procedures involving bones and joints*
15 *A. 1. Each insurer proposing to issue individual or group accident and sickness*
16 *insurance policies providing hospital, medical and surgical or major medical coverage on*
17 *an expense-incurred basis, each corporation providing individual or group accident and*
18 *sickness subscription contracts, each health maintenance organization providing a health*
19 *care plan for health care services and each insurer proposing to issue individual or group*
20 *Medicare supplement policies shall provide coverage under such policy, contract or plan*
21 *delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1994,*
22 *for diagnostic and surgical procedures involving any bone or joint of the skeletal structure*
23 *including any bone or joint of the head, neck, face or jaw if, under accepted standards of*
24 *the treating provider's profession, the procedure is required because of a medical condition*
25 *or injury which prevents normal function of the joint or bone and is deemed medically*
26 *necessary to restore or maintain functional capacity of the affected part.*
27 § 38.2-4319. Statutory construction and relationship to other laws.
28 A. No provisions of this title except this chapter and, insofar as they are not
29 inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218
30 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413,
31 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this
32 title, 38.2-1057, 38.2-1306.2 through 38.2-1310, Article 4 (§ 38.2-1317 et seq.) of Chapter 13,
33 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3411.2, 38.2-3418.1, *38.2-3418.2,*
34 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et
35 seq.) of this title shall be applicable to any health maintenance organization granted a
36 license under this chapter. This chapter shall not apply to an insurer or health services
37 plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§
38 38.2-4200) of this title except with respect to the activities of its health maintenance
39 organization.
40 B. Solicitation of enrollees by a licensed health maintenance organization or by its
41 representatives shall not be construed to violate any provisions of law relating to
42 solicitation or advertising by health professionals.
43 C. A licensed health maintenance organization shall not be deemed to be engaged in
44 the unlawful practice of medicine. All health care providers associated with a health
45 maintenance organization shall be subject to all provisions of law.
46 D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a
47 health maintenance organization providing health care plans pursuant to § 38.2-3431 shall
48 not be required to offer coverage to or accept applications from an employee who does not
49 reside within the health maintenance organization's service area.
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