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# Study of Proposed Mandatory Health Insurance for Temporo-Mandibular Joint Disorders

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A Report to the  
Governor  
and the  
Legislature of  
the State of  
Hawaii



**THE AUDITOR**  
STATE OF HAWAII

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Hawaii

Submitted by

**THE AUDITOR**  
STATE OF HAWAII

Report No. 93-23  
December 1993

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## Foreword

Sections 23-51 and 23-52, Hawaii Revised Statutes, require the State Auditor to study the social and financial impact of measures that propose to mandate health insurance benefits. The purpose of these studies is to give the Legislature an objective basis for evaluating the merits of the proposals. As requested by Senate Concurrent Resolution No. 52, House Draft 2 of the Regular Session of 1993, this report assesses the social and financial impact of mandating health insurance coverage for temporomandibular disorders services.

We wish to express our appreciation for the cooperation and assistance of those state agencies, private insurers, and other interested organizations and individuals whom we contacted during the course of the study.

Marion M. Higa  
State Auditor



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# Table of Contents

## Chapter 1 Introduction

Background on Mandated Health Insurance .....	1
Background on Temporomandibular Disorders .....	3
Current Proposal to Mandate Coverage .....	4
Mandated Coverage in Other States .....	5
Objective of the Study .....	5
Scope and Methodology .....	5

## Chapter 2 Social and Financial Impact of Insurance Coverage for Temporomandibular Disorders Services

Social Impact .....	7
Financial Impact .....	10
Conclusions .....	11

Notes .....	13
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Response of the Affected Agency .....	15
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# Chapter 1

## Introduction

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Sections 23-51 and 23-52, Hawaii Revised Statutes, require the Legislature to pass concurrent resolutions requesting the State Auditor to study the social and financial effects of any proposed legislative measure that would mandate health insurance for specific services, diseases, or providers.

The law stems from legislative concern over the increasing number of these proposals in recent years and their impact on the cost and quality of health care. The purpose of the Auditor's assessment is to provide the Legislature with an independent review of the social and financial consequences of each proposal.

Senate Concurrent Resolution No. 52, House Draft 2 of the Regular Session of 1993 requests the Auditor to assess the social and financial impacts of mandated health insurance coverage for temporomandibular disorders (TMD) services. However, the resolution did not designate any bill that delineates the mandated insurance coverage being proposed.

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## Background on Mandated Health Insurance

Since the 1960s, states have enacted a variety of laws mandating the health coverage that insurers must provide. These laws have required insurers to cover specific medical conditions and treatments, particular groups of people, and the services of certain health practitioners. As of 1992, state governments had enacted over 950 mandates, up from 343 in 1978.<sup>1</sup> However, the growth of mandated coverage appears to be slowing.<sup>2</sup>

### *Arguments for and against mandated health insurance*

Mandated health insurance may be appropriate in certain circumstances. However, proponents and opponents disagree about key issues: whether a particular coverage is necessary, whether it is justified by the demand, whether it will increase the costs of care and by how much, and whether it will increase premiums. Generally, providers and recipients of medical care support mandated health insurance, and businesses and insurers oppose it.

Proponents say gaps in existing coverage prevent people from obtaining the care they need. They believe the current system is not equitable because it does not cover all providers, medical conditions, or needed treatments and services. Proponents also argue that mandated coverage

could increase competition and the number and variety of treatments available. In some instances, it could also reduce costs by making preventive care, early treatment, or alternate care more available.

Opponents argue that mandated benefits add to the cost of employment and production and reduce other more vital benefits. They create particular hardship for small businesses that are less able to absorb rising premium costs. Opponents also argue that mandates reduce the freedom of employers, employees, and unions to choose the coverage they want. Insurers cite premium rates that may rise beyond what employers and consumers are willing to pay. They see mandates as creating an incentive for employers to adopt self-insurance plans that are exempt from the mandates.

### ***Types of insurance plans affected***

Laws to mandate health insurance in Hawaii would affect three main types of private insurance: (1) Blue Cross and Blue Shield plans, (2) health maintenance organizations (HMOs), and (3) commercial insurance plans.

The Hawaii Medical Service Association (HMSA), the Blue Cross and Blue Shield insurer for Hawaii, offers traditional fee-for-service plans (sometimes called indemnity plans) that reimburse physicians and hospitals for services. HMSA also operates a managed care system in which beneficiaries may obtain services from a network of designated providers. In addition, HMSA has an HMO plan that offers a package of preventive and treatment services for a fixed fee. With a 1992 membership of 623,074, HMSA covered about 56 percent of Hawaii's civilian population.<sup>3</sup>

Kaiser Foundation Health Plan is a federally qualified health maintenance organization. As of 1993, it served 189,026 people in Hawaii<sup>4</sup> or about 16 percent of Hawaii's population.

Commercial insurance plans such as HDS (Hawaii Dental Service) Medical, Island Care, and Straub Plan cover the rest of the privately insured population. Some mainland companies, such as Travelers and Aetna, also provide health insurance coverage in Hawaii.

### ***Potential legal challenge***

Hawaii's Prepaid Health Care Act, enacted in 1974, requires employers to provide a qualified prepaid health care plan to regular employees working at least 20 hours per week. A qualified plan is one with benefits that are equal to, or a medically reasonable substitute for, the benefits provided by the plan with the largest number of subscribers in Hawaii.

The federal courts have ruled that the Prepaid Health Care Act is preempted by the federal Employee Retirement Income Security Act (ERISA), which has a provision preempting state laws relating to employment benefit plans. A subsequent congressional amendment exempted Hawaii's Prepaid Health Care Act from ERISA. The exemption, however, applies only to the law as it was enacted in 1974. In effect, this has frozen the law at its original provisions since ERISA would preempt any subsequent amendments. It is possible, therefore, that in Hawaii any mandated benefit laws could be viewed, and challenged, as bypassing the limitations placed on the Prepaid Health Care Act.

### ***Federal health reform proposal***

Health insurance reform is a pressing national issue. President Clinton recently delivered a proposed national Health Security Act to Congress. The proposed legislation contains a basic package of health benefits for all Americans. Significant health insurance reform based on this or other proposals is possible. It is too early to assess the impact of national developments, but they could preempt or otherwise affect state mandated health insurance laws.

### **Background on Temporomandibular Disorders**

The body's temporomandibular joint connects the temporal bone (the temple) and the mandible bone (the lower jaw). TMDs are broadly defined and attributed to many causes. No clear data are available on how many people are afflicted, and there is considerable controversy as to what treatments are appropriate. Both the medical and dental communities treat the disorder.

Although no bill was available to define TMD, the resolution requesting this study says that TMD includes all problems with the functioning of the jaw that may cause headaches, muscle tenderness, and facial, head, or neck pain. The resolution associates TMD with chronic teeth grinding and other causes including trauma, overuse of facial muscles, stress, anxiety, and tension.

### ***TMD treatment***

Treatment of TMD, said *The Wall Street Journal* recently, "has long occupied a medical gray area."<sup>5</sup>

In 1982 the Council on Dental Care Programs of the American Dental Association concluded that "many pathologic, traumatic, developmental, and psycho-physiologic conditions may contribute to head, face, and neck pain and TMJ [temporomandibular joint] disorders." The council observed that it is not "a single problem to be resolved through a single course of treatment."<sup>6</sup>

Both surgical and nonsurgical techniques have been used. Physicians and dentists may differ on what is most appropriate. Treatment may involve one or more of the following:

- Soft diet
- Anti-inflammatory medication
- Physical therapy
- Dental splint therapy
- Chiropractic therapy
- Orthognatic (jaw) therapy
- Orthodontic work
- Prostheses
- Dental reconstruction
- Temporomandibular joint surgery (arthroscopic or open joint)

### ***Practitioners***

In addition to general dentists, specialists who treat TMD include practitioners of orthodontics, oral medicine, oral and maxillofacial surgery, endodontics, periodontics, and prosthodontics. Medical doctors may treat problems in the temporomandibular area resulting from diseases such as cancer and trauma such as auto accidents. Orthopedic surgeons generally prefer not to operate on TMD patients because of the risk of damaging the brain, ear, and facial nerves. Oral and maxillofacial surgeons have been less hesitant.<sup>7</sup>

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### **Current Proposal to Mandate Coverage**

As previously noted, Senate Concurrent Resolution No. 52, H.D. 2 did not designate any bill that delineated the mandated insurance benefits for TMD services. However, a good deal of testimony was presented on the resolution requesting the study.

The State Auditor was unable to support the resolution because there was no bill on which to base an assessment of the social and financial impact of mandating coverage. Such a bill should include, at a minimum, information identifying the specific health service, disease, or provider that will be covered; the extent of the coverage; the target groups that will be covered; limits on utilization, if any; and standards of care. Without this type of specific information, any assessment would be limited in usefulness.

The HMSA felt the study was not necessary because: (1) HMSA already covers standard medical care for persons who suffer serious functional impairment in the temporomandibular area; (2) the controversy as to the efficacy of major and sometimes radical TMD treatments cannot be resolved by a study of the social and financial impact of coverage; and (3) no consumer demand has been demonstrated for these services.

Several organizations and individuals testified in support of the study. They included the Commission on Persons with Disabilities, the Hawaii Dental Association, the Hawaii Federation of Physicians and Dentists, the Hawaii Society of Oral and Maxillofacial Surgeons, several dentists specializing in oral and maxillofacial surgery, and an emergency room physician. Proponents of the study gave such reasons as the debilitating effects of TMD, the success of early conservative treatment in preventing the need for more costly treatment, and the frequent unavailability of medical care due to the lack of insurance coverage.

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### **Mandated Coverage in Other States**

In 1992 the American Dental Association (ADA) issued a policy statement that encouraged all third-party payers to offer benefit coverage for diagnosis and treatment of bone and joint disorders without discriminating between medical doctors and dentists. The ADA also recommended that all third-party payers coordinate coverage between medical and dental plans to eliminate any disparity in benefits coverage and reimbursement for such disorders.<sup>8</sup> In January 1993, the ADA reported that 11 states had laws, regulations, or directives mandating TMD coverage on the same basis as other joint disorders.<sup>9</sup>

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### **Objective of the Study**

The objective of our study was to describe the social and financial effects of mandating health insurance coverage for temporomandibular disorders services.

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### **Scope and Methodology**

It is important to note that our study examined the impact of mandated *insurance coverage* for TMD services and not the impact of the services themselves.

Our work was significantly limited for three reasons. First, TMD, its victims, and the services needed have not been clearly defined. Second, little data are available on utilization and costs. Finally, no bill had been designated for us to study so there was little to assess.

To the extent possible, however, we considered the following issues set forth by the law:

### ***Social impact***

1. Extent to which TMD treatment or services are generally utilized by a significant portion of the population.

2. Extent to which insurance coverage for TMD services is already generally available.
3. Extent to which the lack of coverage results in persons being unable to obtain necessary treatment.
4. Extent to which the lack of coverage results in unreasonable financial hardship on persons needing treatment.
5. Level of public demand for TMD services.
6. Level of public demand for individual or group insurance coverage of TMD services.
7. Level of interest of collective bargaining organizations in negotiating privately for this coverage.
8. Impact of providing coverage for TMD services on health status, quality of care, practice patterns, provider competition, or related items.
9. Impact of indirect costs upon the costs and benefits of coverage.

### ***Financial impact***

1. Extent to which the insurance coverage would increase or decrease the cost of TMD services.
2. Extent to which insurance coverage might increase use of TMD services.
3. Extent to which mandated TMD services might serve as an alternative to more expensive treatment or services.
4. Extent to which insurance coverage of TMD services might increase or decrease the insurance premiums or the administrative expenses of policyholders.
5. Impact of insurance coverage for TMD services on the total cost of health care.

In carrying out the study, we reviewed and analyzed research literature and information obtained through interviews of commercial insurers, mutual benefit societies, health maintenance organizations, employer groups, collective bargaining organizations, professional associations, state agencies, and national experts. We did not test the data provided.

Our work was performed from May 1993 through December 1993 in accordance with generally accepted government auditing standards.

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# Chapter 2

## Social and Financial Impact of Insurance Coverage for Temporomandibular Disorders Services

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This chapter summarizes the results of our efforts to assess the potential social and financial impact of mandating health insurance coverage for temporomandibular disorders (TMD) services. The discussion is limited because of limited consensus, information, and data available on TMD, and by the absence of a designated legislative proposal on which to base our assessment.

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### Social Impact

#### 1. Extent to which TMD treatment or services are generally utilized by a significant portion of the population.

TMD covers a broad range of disorders attributable to many causes. Many joint and muscle disorders come under the rubric of TMD. Little reliable data were available on the extent to which TMD services are used and whether these services are used by a significant portion of the population. Estimates of the number of afflicted persons vary. The extent to which TMD services are necessary is also unclear, with much controversy over such fundamental issues as the degree to which the disorder will correct itself and the appropriateness of surgery.

According to Samuel Dworkin, an expert on the subject, TMDs are the most common orofacial pain condition seen by dentists and other health care providers. An epidemiological study conducted by Dr. Dworkin in 1990 found TMD-related pain reported by 12.1 percent of the population sampled.<sup>1</sup> TMD pain in the sample occurred with about the same prevalence as abdominal and chest pain. Another study by a physician-dentist team reported TMD prevalence at up to 30 percent of the population. The team defined TMD as any abnormality in joint function that impairs the mobility of the mandible.<sup>2</sup>

Still another prevalence study found joint/muscle disorders in 27 percent of a group of nursing students. However, the study estimated that only about 5 percent of people afflicted with TMD needed treatment. The study suggested that most people with clinically detectable dysfunction are functioning adequately without significant symptoms and do not need treatment.<sup>3</sup> A letter from the Hawaii Dental Association (HDA) estimates that 13 percent of Hawaii's population suffers from TMD.<sup>4</sup> No estimate was given of the percentage or number that might need treatment.

**2. Extent to which insurance coverage for TMD services is already generally available.**

Hawaii's major health insurers do not cover TMD as such. At one time HMSA covered TMD services but stopped doing so for cost considerations, and apparently it has not been able to resolve the issue with dentists. HMSA's basic plan explicitly excludes diagnosis or treatment of temporomandibular joint problems or malocclusion. However, HMSA will pay for the surgical correction of conditions caused by accidental injuries and for treatment of documented disease such as arthritis or cancer relating to the temporomandibular joint. It will not pay for pain in the jaw that cannot be localized or for radical surgery for TMD.

HMSA is considering whether to cover TMD services in the light of their medical necessity, efficacy, and safety. Officials point to controversy over what TMD is, which treatments are appropriate, and whether it is a dental or medical problem. They feel a consensus is likely to evolve eventually but it is premature now to mandate the coverage.

Kaiser in Hawaii does not cover dental care and specifically excludes "TMJ [temporomandibular joint] dysfunction" for this reason. A Kaiser official said that TMD is not readily identifiable by any criteria and there is no checklist for diagnosing it. However, Kaiser provides some TMD treatment when this is defined as medically necessary by Medicare. Kaiser may also treat some TMD that is identified by medical doctors.

HDS (Hawaii Dental Service) Medical informed us that it does not cover TMD.

According to the Hawaii Dental Association, benefits are currently available to TMD patients through workers compensation, no fault medical insurance, and several mainland insurers, such as Travelers, Aetna, and Massachusetts Mutual.

**3. Extent to which the lack of coverage results in persons being unable to obtain necessary treatment.**

We found no reliable data on the numbers afflicted with TMD in Hawaii or the numbers needing treatment. Consequently, we found no data on the extent to which lack of insurance coverage prevents people from obtaining treatment.

**4. Extent to which the lack of coverage results in unreasonable financial hardship on persons needing treatment.**

Treatment for TMD varies widely as do the costs for treatment. No sufficient data are available on whether the lack of coverage has resulted in financial hardship. The Hawaii Dental Association claims that costs for a regimen of patient education, dietary instruction, physical therapy, biofeedback training, and a bite splint may be between \$1,000 and \$4,000. It says that this would be prohibitive for 50 to 75 percent of patients who do not have insurance benefits.<sup>5</sup>

**5. Level of public demand for TMD services.**

Again, lack of data makes it difficult to assess the demand for TMD services.

**6. Level of public demand for individual or group insurance coverage of TMD services.**

We found little evidence of public demand for insurance coverage for TMD services. HMSA reports no demand from its employer groups. Kaiser reports little demand from consumers.

The demand for coverage comes not from consumers or physicians but primarily from the dental community and oral surgeons in particular. The Hawaii Dental Association, the Hawaii Federation of Physicians and Dentists, and the Hawaii Society of Oral and Maxillofacial Surgeons favor coverage. They contend that (1) TMDs are a major cause of patient pain and dysfunction and have even led to suicide; (2) sufferers lacking coverage go with minimal treatment; (3) both medical and dental insurance coverage should be required; (4) the majority of patients can be treated with a conservative regimen of medical and dental therapy; (5) less than 15 percent eventually require jaw or jaw joint surgery; (6) the incidence of surgery could probably be reduced if patients had access to comprehensive nonsurgical treatment before the disorder became severe; and (7) the pathologic diagnoses for the temporomandibular joint are similar to any other joint in the body and include osteoarthritis, joint dislocation, and other conditions for which people expect to be covered.

**7. Level of interest of collective bargaining organizations in negotiating privately for this coverage.**

Union representatives had few observations about TMD coverage. Three indicated little discussion of TMD has occurred. Two said there was little information on TMD, and one said that probably few people have TMD and the union tries to benefit the *most* people.

**8. Impact of providing coverage for TMD services on health status, quality of care, practice patterns, provider competition, or related items.**

No reliable information was available on the possible impacts of providing coverage for TMD services on general health status, quality of care, practice patterns, or provider competition.

**9. Impact of indirect costs upon the costs and benefits of coverage.**

We could find no information on indirect costs.

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## Financial Impact

**1. Extent to which the insurance coverage would increase or decrease the cost of TMD services.**

Without sufficient baseline data on the use or cost of TMD services, we could find no reliable data on the extent to which insurance coverage might increase or decrease the cost of TMD services. Since insurers do not cover TMD as a specific disease entity, they do not keep this kind of information.

**2. Extent to which insurance coverage might increase the use of TMD services.**

Minnesota enacted mandated medical coverage for TMD in 1987. In comparing the use of TMD services before and after the mandate, Minnesota found that the mandate increased the number of patients receiving care by 338 percent.<sup>6</sup>

Without any specific information on what mandated coverage is being proposed, we could not assess the extent to which insurance coverage might increase the use of TMD services in Hawaii. The Hawaii Dental Association estimates that costs for TMD services prohibit utilization for approximately 50 to 75 percent of patients. The dental association did not provide us with any data on the numbers of patients who might be affected by the lack of insurance.

**3. Extent to which mandated TMD services might serve as an alternative to more expensive treatment or services.**

It is possible that coverage for TMD services could serve as an alternative to more expensive treatment and services. Early, nonsurgical treatment, such as the use of splints and physical therapy, could be used successfully with a high percentage of patients.

Again, Minnesota found that the cost of care showed a reduction of 13.8 percent despite inflation and the increased number of patients receiving care. The cost reduction was attributed to treatment by respected clinics that are conservative in using diagnostic tests and that provide care at an earlier stage in the development of the problem when care is simpler and less extensive.<sup>7</sup> It should be noted that Minnesota has developed careful guidelines for the proper evaluation, diagnosis, and treatment of TMD, including nonsurgical and surgical guidelines. Insurers there have also instituted a policy of prior authorization before initiating treatment.

**4. Extent to which insurance coverage of TMD services might increase or decrease the insurance premiums or the administrative expenses of policyholders.**

We found no data on the extent to which insurance coverage might increase insurance premiums or administrative expenses.

**5. Impact of insurance coverage for TMD services on the total cost of health care.**

Minnesota has found some reduction in the cost of care. Whether the same conditions would exist in Hawaii under similar legislation cannot be determined at this time.

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## Conclusions

Because of insufficient data and the lack of a specific legislative proposal, we could not assess what the impact of mandated coverage of TMD services might be. We did determine that, for the most part, it is the dental community—particularly the oral and maxillofacial surgeons—that is creating the demand for coverage.

In conclusion, several cautionary notes are appropriate. Before deciding on whether TMD services should be mandated, it may be best to see what kind of federal health care package will be enacted. The Council of State Governments has also cautioned that “because the cost of health insurance has a significant impact on the health care delivery system in the states, states must evaluate whether certain mandated health benefits, for example, temporomandibular disorders are worth the cost that would be added to the basic health insurance coverage.”<sup>8</sup>

Finally, an editorial in *The Journal of Craniomandibular Practice* states that the TMD field is still in its infancy and changes are best accomplished through a coordinated effort among university programs, state dental associations, and health care providers in the field. The editorial urged that guidelines be developed for TMD treatment and for

diagnostic tests that have scientific support and broad based agreement regarding their usefulness. In addition, criteria are needed for the use of various diagnostic and treatment modalities.<sup>9</sup>

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## Notes

### Chapter 1

1. Susan S. Laudicina, *Impact of State Basic Benefit Laws on the Uninsured*, Blue Cross and Blue Shield Association, December 1992, p. 1; Jon R. Gabel and Gail A. Jensen, "The Price of State Mandated Benefits," *Inquiry*, vol. 26, winter 1989, p. 420.
2. Laudicina, *Impact of State Basic Benefit Laws*, p. 2.
3. Information provided by HMSA to the Office of the Auditor, November 17, 1993.
4. Letter to Jessica Hashimoto, Analyst, Office of the Auditor, from Francie Boland, Counsel, Kaiser Permanente, November 16, 1993.
5. Bruce Ingersoll and Rose Gutfeld, "Medical Mess: Implants in Jaw Joint Fail, Leaving Patients in Pain and Disfigured," *The Wall Street Journal*, August 31, 1993, p. 1.
6. Council on Dental Care Programs, "Prepayment Plan Benefits for Temporomandibular Joint Disorders," *Journal of the American Dental Association*, vol. 105, September 1982, pp. 485-86.
7. Ingersoll and Gutfeld, "Medical Mess," p. 1.
8. American Dental Association, Council on Dental Care Programs, *Policies on Dental Care Programs 1992*, Chicago, Illinois, p. 42.
9. American Dental Association, Department of State Government Affairs, "TM Treatment and Third Party Insurance Coverage," Chicago, Illinois, January 21, 1993, p. 1.

### Chapter 2

1. Samuel F. Dworkin et al., "Epidemiology of Signs and Symptoms in Temporomandibular Disorders: Clinical Signs in Cases and Controls," *Journal of the American Dental Association*, vol. 120, March 1990, p. 279.
2. Brendan C. Stack, Jr. and Brendan C. Stack, Sr., "Temporomandibular Joint Disorder," *American Family Physician*, vol. 46, no. 1, pp. 143-45.

3. Eric L. Schiffman and Dennis P. Haley, "The Prevalence and Treatment Needs of Subjects with Temporomandibular Disorders," *Journal of the American Dental Association*, vol. 120, March 1990, pp. 299, 301, 303.
4. Letter to Jessica Hashimoto, Analyst, Office of the Auditor from George A. Wessberg, DDS, Chairperson, Legislative Committee, Hawaii Dental Association, November 19, 1993.
5. *Ibid.*, p. 2.
6. James R. Fricton, "Minnesota Mandates Medical Coverage for TMD," *The Journal of Craniomandibular Practice*, vol. 9, no. 1, January 1991, p. 2.
7. *Ibid.*, p. 2.
8. "Temporomandibular Disorders (TMD)," *CSG Backgrounder*, July 1990, p. 4.
9. Fricton, "Minnesota Mandates Medical Coverage for TMD," p. 3.

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## Response of the Affected Agency

### Comments on Agency Response

We transmitted a draft of this report to the Department of Health on December 15, 1993. A copy of the transmittal letter to the department is included as Attachment 1. The response from the department is included as Attachment 2.

The department says that much of the controversy revolves around the labeling of temporomandibular joint disorders as dental problems with little regard for the debilitating impact that the disease can have on some individuals. As a result, TMDs are covered inconsistently by "medical" plans since they are considered "dental" problems. The department comments that while severe TMD problems appear not to be a major public health problem, many people would benefit from third-party assistance when therapy is needed. The department is willing to see a local consensus on TMD policy through Hawaii's health care reform process.

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December 15, 1993

**COPY**

The Honorable John C. Lewin  
Director of Health  
Department of Health  
1250 Punchbowl Street  
Honolulu, Hawaii 96813

Dear Dr. Lewin:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Study of Proposed Mandatory Health Insurance for Temporo-Mandibular Joint Disorders*. We ask that you telephone us by Friday, December 17, 1993, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Monday, December 27, 1993.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa  
State Auditor

Enclosures

JOHN WAIHEE  
GOVERNOR OF HAWAII



JOHN C. LEWIN, M.D.  
DIRECTOR OF HEALTH

STATE OF HAWAII  
DEPARTMENT OF HEALTH

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HONOLULU, HAWAII 96801

In reply, please refer to:  
File:

December 27, 1993

Mrs. Marion M. Higa  
State Auditor  
Office of the State Auditor  
465 South King Street  
Honolulu, Hawaii 96813-2917

RECEIVED  
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OFC. OF THE AUDITOR  
STATE OF HAWAII

Dear Mrs. Higa:

Thank you for the opportunity to review and comment on your draft report, Study of Proposed Mandatory Health Insurance for Temporo-Mandibular Joint Disorders, which you sent to me for comment on December 15, 1993.

Much of the controversy revolves around the industry (generally) labeling disorders involving the temporo-mandibular joint as dental problems with little regard the truly debilitating impact joint disease can have on some individuals. As a result, TMD problems are inconsistently covered by "medical plans" because they are "dental problems." This is very unfortunate considering that early intervention in TMD can greatly reduce an individual's risk of chronic disability and suffering related to end stage TMD, including degenerative arthritis.

While it appears that severe TMD problems are not a major public health problem, many in our community would greatly benefit from the availability of third-party assistance when therapy is needed.

It doesn't appear that either the TMD question or dental services will be addressed in the initial phases of the federal health care reform package. The DOH is willing to see a local consensus on policy relating to TMD through Hawaii's health care reform process over the next few years.

Very truly yours,

JOHN C. LEWIN, M.D.  
Director of Health