
Study of Proposed Mandatory Health Insurance for Treatment of Orofacial Anomalies

A Report to the
Governor
and the
Legislature of
the State of
Hawai'i

Report No. 14-08
September 2014



THE AUDITOR
STATE OF HAWAI'I

Office of the Auditor

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Under its assigned missions, the office conducts the following types of examinations:

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Between 2007 and 2012, 61 babies with a cleft lip or palate and 83 babies with craniofacial defects were born at Kapi'olani Medical Center for Women and Children alone.

Recommendation

Response

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Study of Proposed Mandatory Health Insurance for Treatment of Orofacial Anomalies

Report No. 14-08, September 2014

Mandatory health insurance for treatment of orofacial anomalies is recommended

In House Concurrent Resolution No. 100, the 2014 Legislature asked the Auditor to assess the social and financial effects of mandating health insurance coverage for medically necessary orthodontic treatment of persons with orofacial anomalies, as proposed in House Bill (HB) No. 2522. Specifically, the bill would require each health insurance contract, plan, policy, or agreement issued or renewed after December 31, 2014, to include benefits for direct or consultative services provided by a licensed orthodontist for the correction of teeth that come together abnormally, preparation of patients for surgery, or correction of facial deformities in conjunction with surgery. Health insurance coverage would apply to policyholders and persons under age 26. Although benefits would be limited to \$5,000 per treatment phase, there would be no limit on the number of visits to an orthodontist.

HB No. 2522 defines orofacial anomalies as a "cleft lip or cleft palate and other birth defects of the face and mouth affecting functions such as eating, chewing, speech, and respiration." In Hawai'i, approximately one in 500 babies is born with an orofacial anomaly.

Social impacts to patients are significant

Our analysis on the social and financial impacts of mandating health insurance coverage for medically necessary orthodontic services of orofacial anomalies is based on survey responses, literature review, and interviews. In addition to the Department of Health's (DOH) Children with Special Health Needs Branch of the Family Health Services Division and the Kapi'olani Cleft Center, we sent surveys to four private health insurance companies: Hawai'i Medical Service Association (HMSA); Kaiser Permanente Hawai'i (Kaiser); University Health Alliance (UHA) and Hawai'i Medical Assurance Association (HMAA).

The lack of insurance coverage for medically necessary orthodontic services for orofacial anomalies places a significant hardship on families that cannot receive grants or qualify for state assistance through the DOH's Children with Special Health Needs Program (CSHNP). Treatment cost estimates range from approximately \$5,700 to \$20,000 or more. In testimony to the 2014 Legislature, families facing such expenses said they pose a significant hardship, particularly for orthodontia treatment that is medically necessary to progress from one surgery to another procedure. One such parent, a public school teacher, testified that the family simply could not afford to pay out of pocket and said it is unfair that the treatment would be covered by Med-QUEST, but not the family's private insurer. The DOH says mandatory coverage would ease the financial burden and hardship facing 44 families enrolled in the CSHNP with commercial health plans.

Financial impacts on insurers are minimal

Three insurers (HMAA, HMSA, Kaiser) could not say whether coverage will increase or decrease insurance premiums. UHA reported premiums and costs would increase but could not provide estimates. DOH cites reports from California and Massachusetts indicating that mandated insurance coverage for orofacial anomalies increased premiums by two cents to four cents per member, per month, or less; however, Hawai'i's insurance premium cost increases are unknown since HMAA, HMSA, and Kaiser were unable to provide any estimates without more detailed analysis.

Agencies' responses

On September 4, 2014, we transmitted a draft of this report to the Departments of Health and Commerce and Consumer Affairs. The departments opted not to respond.

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Submitted by

THE AUDITOR
STATE OF HAWAI'I

Report No. 14-08
September 2014

Foreword

We assessed the social and financial impacts of mandating insurance coverage for medically necessary orthodontic treatment of orofacial anomalies as proposed in House Bill No. 2522 (2014), pursuant to Sections 23-51 and 23-52, Hawai‘i Revised Statutes (HRS). Section 23-51, HRS, requires passage of a concurrent resolution requesting an impact assessment by the Auditor before any legislative measure mandating health insurance coverage for a specific health service, disease, or provider can be considered. The 2014 Legislature requested this assessment through House Concurrent Resolution No. 100.

We wish to express our appreciation for the cooperation and assistance extended to us by the Hawai‘i State Department of Health, Children with Special Health Needs Branch, and other organizations and individuals we contacted during the course of our audit.

Jan K. Yamane
Acting State Auditor

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Chapter 1

Introduction

In House Concurrent Resolution No. 100, the 2014 Legislature asked the Auditor to assess the social and financial effects of mandating health insurance coverage for medically necessary orthodontic treatment of persons with orofacial anomalies, as proposed in House Bill No. 2522 of the 2014 regular session. We conducted this study in accordance with Sections 23-51 and 23-52, Hawai‘i Revised Statutes (HRS). Section 23-51, HRS, requires passage of a concurrent resolution requesting an impact assessment by the Auditor before any legislative measure mandating health insurance coverage for a specific health service, disease, or provider can be considered. The resolution must designate a specific bill that has been introduced in the Legislature and includes, at a minimum, information identifying the:

- Specific health service, disease, or provider that would be covered;
- Extent of the coverage;
- Target groups that would be covered;
- Limits on utilization if any; and
- Standards of care.

Background

Orofacial anomalies and children

House Bill (HB) No. 2522 defines *orofacial anomalies* as a “cleft lip or cleft palate and other birth defects of the face and mouth affecting functions such as eating, chewing, speech, and respiration.” Cleft lip and cleft palate are also known as *orofacial clefts*. A cleft lip happens if the tissue forming the lip does not join completely before birth. This results in an opening in the upper lip, which can be a small slit or a large opening that goes through the lip into the nose. Cleft palate occurs when tissue that makes up the roof of the mouth does not join together, leaving a gap in the roof of the mouth. A baby can have a cleft lip, cleft palate, or both. The Centers for Disease Control and Prevention estimates about 2,650 babies are born in the U.S. each year with a cleft palate and 4,440 babies are born with a cleft lip with or without a cleft palate, an incidence rate of about 0.1 percent. In Hawai‘i, approximately one in 500 babies is born with an orofacial anomaly,¹ which equals approximately 0.2 percent of births or 37 per year based on the average number of live births in

¹ One in 500 incidence provided by the Hawai‘i Department of Health based on data from Kapi‘olani Medical Center for Women and Children. One in 500 birth rate also cited in House Concurrent Resolution No. 100 as the incidence rate in Hawai‘i.

the state from 2003 to 2012. Between 2007 and 2012, 61 babies with a cleft lip and palate and 83 babies with craniofacial defects were born at Kapi‘olani Medical Center for Women and Children alone.

Children with orofacial clefts may have problems feeding and speaking. They also may have problems hearing and with their teeth. Surgery to treat an orofacial cleft is recommended within a child’s first 18 months of life; many children need additional operations as they grow older.

Orofacial anomalies are generally treated by a team of health care specialists, including audiologists, maxillofacial surgeons, plastic surgeons, otolaryngologists, and neurosurgeons. The minimum core team, according to the American Cleft Palate-Craniofacial Association, includes speech-language pathologists, surgeons, and orthodontists.

Orthodontic services for treating orofacial anomalies

House Bill No. 2522 recognizes the team approach as the care standard, as the bill’s definition of treatment for orofacial anomalies includes care prescribed or provided “by a craniofacial² team that includes a licensed dentist, orthodontist, oral surgeon, and physician, and is coordinated between specialists and providers.” The bill defines orthodontic services as “direct or consultative services provided by a licensed orthodontist.”

Orthodontia may be required to treat orofacial anomalies for any of several reasons as a direct result of the medical condition and as an integral part of the habilitative process. Treatment occurs in phases from infancy and may extend through adulthood for primary, transitional, and permanent dentition. Treatment and examinations may be necessary to correct teeth that come together abnormally, prepare patients for surgery or to correct facial deformities in conjunction with surgery, and to monitor growth and development of the face and mouth. Other orthodontic services may require dental films, photographs, and computer imaging; diagnostic records such as dental study models; orthodontic appliances; fixed restorative bridgework; and prosthetic speech appliances.

When indicated, orthodontic treatment may prepare a patient for bone grafting that is commonly needed to close a gap in the upper jaw or bone structure beneath the patient’s gum line. This is known as *alveolar* bone grafting. Orthodontic treatment may be needed before and after the alveolar bone graft.

² House Bill No. 2522 mandates coverage for *orofacial* anomalies, which it defines as “cleft lip or cleft palate and other birth defects of the face and mouth.” Orofacial also may be defined as “relating to the mouth and face.” The term *craniofacial* is also used by several other states and organizations and in HB No. 2522. Craniofacial means “of, relating to, or involving the cranium and face.” Craniofacial and orofacial are both used to describe cleft lip and cleft palate.

A registered nurse who helps oversee the Cleft and Craniofacial Center at Kapi‘olani Medical Center explained that this orthodontic treatment is performed not for cosmetic purposes, but rather to help reconstruct a birth defect or birth anomaly and produce a more optimal result for the patient.

The Hawai‘i Department of Health estimates that the average cost to treat orofacial anomalies, including an average of five surgeries and non-surgical care, is \$100,000 over a patient’s lifetime. Orthodontic services may account for nearly 15 percent, or \$15,000, of that total. The cost of each orthodontic treatment phase can range from \$2,800 for the first phase and \$5,000–\$6,000 for the second and third phases. House Bill No. 2522 provides a maximum benefit of \$5,000 for each treatment phase.

State- and federally-funded programs cover treatment of orofacial anomalies

Government programs pay for orthodontic services for treating certain orofacial anomalies for some persons. Children who are covered through the State’s Med-QUEST programs administered by the Department of Human Services’ Med-QUEST Division may receive limited coverage for medically necessary orthodontic treatments for orofacial anomalies. The Med-QUEST programs review recommendations from teams of medical, dental, and craniofacial experts before approving orthodontic treatment for these children.

Also providing support is the Children with Special Health Needs Program (CSHNP), a statewide program for infants, children, and youth up to age 21 who have or may have long-term or chronic health conditions requiring specialized medical care, such as orofacial anomalies. Located within the Department of Health’s Family Health Services Division, Children with Special Health Needs Branch, the program coordinates services to families without regard to income. To receive limited financial assistance, families must meet the program’s financial criteria (267 percent of Federal Poverty Guidelines). The program pays for orthodontic treatments for certain types of cleft lip and cleft palate conditions for children. Families with private insurance may qualify for the state benefit, which is paid for with state general fund moneys, if their private insurance does not cover the treatment. To qualify, a family of four must have an annual gross income less than \$73,140. The maximum benefit is \$2,500 or \$4,800 per treatment phase, depending on the phase. From 2008 to 2013, the program paid a total of \$50,938, or an average of \$8,490 per year, and treated 12 children.

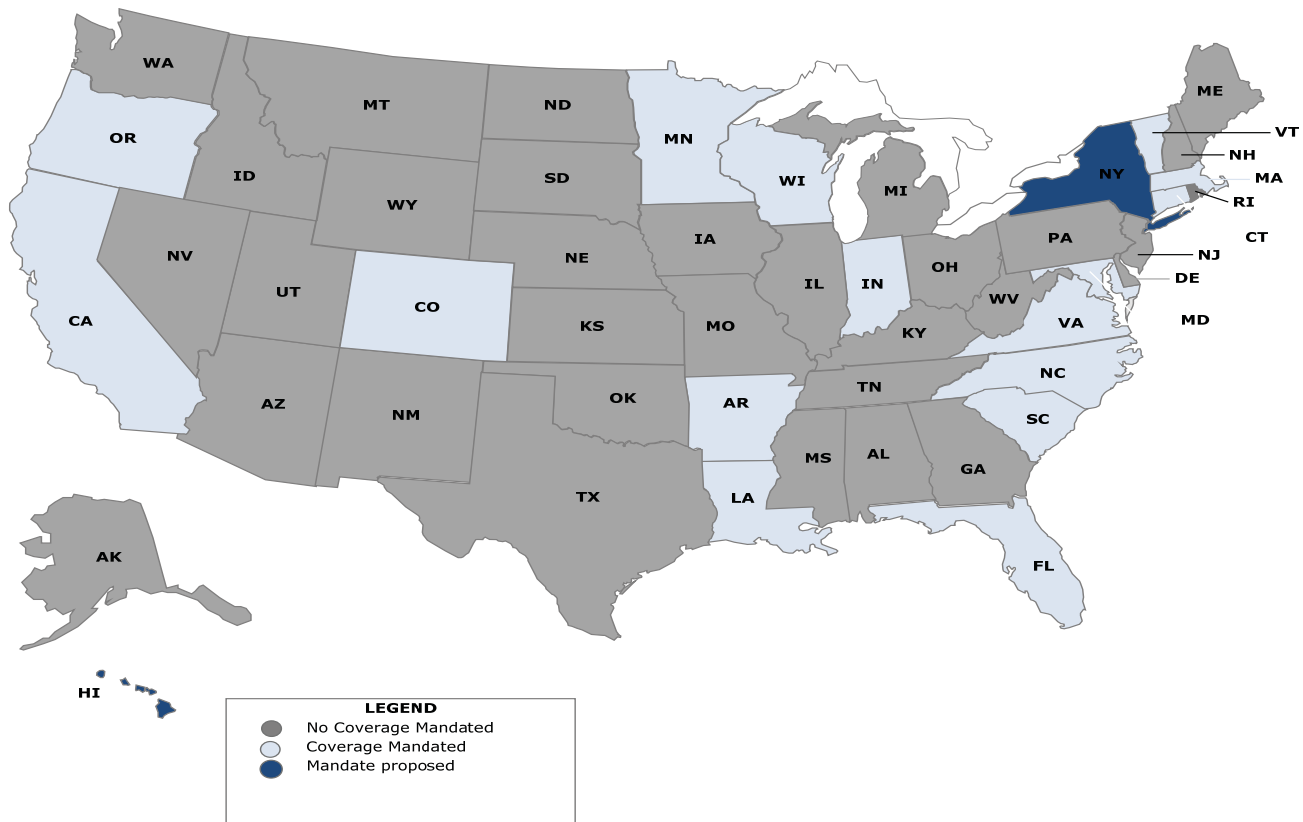
House Bill No. 2522 requires coverage for orthodontic services for orofacial anomalies for persons under age 26

The purpose of HB No. 2522 is to promote quality health care procedures in the state by requiring private health insurers to cover medically necessary orthodontic treatment of orofacial anomalies. Specifically, the bill adds new sections to Article 10A in Chapter 431, HRS, and Article 1 in Chapter 432, HRS, and amends Section 432D-23, HRS, requiring each health insurance contract, plan, policy, or agreement issued or renewed after December 31, 2014, to include benefits for direct or consultative services provided by a licensed orthodontist. Health insurance coverage would apply to policyholders and persons under age 26. While benefits are limited to \$5,000 per treatment phase, there is no limit on the number of visits to an orthodontist.

Coverage in other states

As of July 2014, 16 states have laws requiring private health insurers to cover orthodontics used to treat cleft lip or palate, craniofacial disorders, or other birth defects requiring orthodontic treatment. Thirty-four states have no such laws, although two states, including Hawai‘i, are considering such proposals. Exhibit 1.1 illustrates which states provide coverage and identifies those where insurance coverage is not available.

**Exhibit 1.1
Map of Insurance Coverage for Orofacial Anomalies**



Source: Office of the Auditor

Objectives of the Study

1. Assess the social and financial effects of mandating health insurance coverage for medically necessary orthodontic treatments for persons with orofacial anomalies.
2. Make recommendations as appropriate.

Scope and Methodology

Our study examined the social and financial effects of mandating health insurance coverage for medically necessary treatment of orofacial anomalies as proposed in House Bill No. 2522.³ To assess the potential social and financial effects of providing coverage for medically necessary orthodontic services as defined in the bill for treating orofacial anomalies, we applied the following criteria provided in Section 23-52, HRS, as applicable:

Social impact

1. Extent to which the treatment or service is generally utilized by a significant portion of the population;
2. Extent to which such insurance coverage is already generally available;
3. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;
4. If coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;
5. The level of public demand for the treatment or service;
6. The level of public demand for individual or group insurance coverage of the treatment or service;
7. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;
8. The impact of providing coverage for the treatment or service (such as morbidity, mortality, quality of care, change in practice patterns, provider competition, or related items); and

³ This study does not examine the effects of HB No. 2522 in light of the federal Patient Protection and Affordable Care Act (ACA). Although two insurers raised questions concerning the interplay between HB No. 2522 and the ACA, the Legislature did not expand the scope of the study to include such an analysis.

9. The impact of any other indirect costs upon the costs and benefits of coverage as may be directed by the Legislature or deemed necessary by the Auditor in order to carry out the intent of this section.

Financial impact

1. The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;
2. The extent to which the proposed coverage might increase the use of the treatment or service;
3. The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;
4. The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policy holders; and
5. The impact of this coverage on the total cost of health care.

We conducted this study between May 2014 and July 2014 in accordance with the Office of the Auditor's *Manual of Guides* and Sections 23-51 and 23-52, HRS.

Chapter 2

Proposed Mandatory Health Insurance for Treatment of Orofacial Anomalies Is Recommended

This study assesses the social and financial impacts of mandating insurance coverage for medically necessary orthodontic services for treating orofacial anomalies prescribed by a craniofacial team as proposed in House Bill No. 2522 of the 2014 regular session (HB No. 2522). Treatment for orofacial anomalies as defined in HB No. 2522, for direct or consultative services by a licensed orthodontist, is not generally available as a benefit covered by Hawai'i's private health insurers; however, it is covered for eligible families enrolled in programs administered through the state Department of Human Services' Med-QUEST Division. As a consequence, families with private health insurance often must pay for orthodontic services out of pocket, with private grants, or with financial assistance from the state Children with Special Health Needs Program administered by the Family Health Services Division of the Department of Health (DOH).

Summary of Findings

1. The social impacts of orofacial anomalies are significant because insurance coverage is not generally available to a significant portion of children born with orofacial anomalies needing orthodontic services. Insurance coverage is not expected to increase cost and use of treatment; however, it would likely decrease costs to individuals while shifting costs to insurers.
2. Sixteen states mandate health insurance coverage for medically necessary orthodontic services for the treatment of orofacial anomalies similar to House Bill No. 2522.

Social and Financial Impacts Argue for Mandatory Coverage

Our analysis on the social and financial impacts of mandating health insurance coverage for medically necessary orthodontic services of orofacial anomalies is based on survey responses, literature review, and interviews. In addition to the DOH Children with Special Health Needs Branch of the Family Health Services Division and the Cleft and Craniofacial Center at Kapi'olani Medical Center for Women and Children (Kapi'olani Cleft Center), we sent surveys to four private health insurance companies:

- Hawai‘i Medical Service Association (HMSA);
- Kaiser Permanente Hawai‘i (Kaiser);
- University Health Alliance (UHA); and
- Hawai‘i Medical Assurance Association (HMAA).

All of the above insurers responded to the survey. Exhibit 2.1 shows the total membership for each respondent.

**Exhibit 2.1
Membership of Respondent Health Insurers**

Private Health Insurers	Number of Members
HMSA	734,610 ¹
Kaiser	230,000
UHA	51,216
HMAA	43,869

Source: Office of the Auditor, based on responses from private health insurers

Overall, we found that insurance coverage in Hawai‘i varies for medically necessary orthodontic services for orofacial anomalies as defined in HB No. 2522. HMSA said orthodontic treatment of orofacial anomalies is not a covered benefit. By contrast, Kaiser Permanente-Hawai‘i, which is the sole insurer that supports passage of HB No. 2522, provides coverage to its members. Kaiser provides treatment for approximately 15–20 orofacial anomaly patients per year and has provided orthodontics for about 90 percent of those. In contrast to Kaiser, HMAA says it provides coverage for medically necessary orofacial anomalies but has provided no such coverage for orthodontic treatment, even though it provided other coverage to six orofacial anomaly patients since January 2013, including one surgery. UHA said there might be instances in which it covers orthodontic treatment of orofacial anomalies, but it has never covered such treatment.

¹ HMSA asserts that the mandate contemplated under House Bill No. 2522 would exempt qualified health plans under the federal Patient Protection and Affordable Care Act. If so, only 280,000 of HMSA’s membership would be affected, not its total membership of 734,610.

Social impacts are significant for children born with orofacial anomalies

Based on the responses to our survey described below, we conclude that the social impact of mandating coverage for medically necessary orthodontic treatment for orofacial anomalies would be significant and warrants coverage.

1. Extent to which the treatment or service is generally utilized by a significant portion of the population

Medically necessary orthodontic treatment for orofacial anomalies is not used by a significant portion of the population as a whole. In Hawai‘i only an estimated one in 500 babies is born with an orofacial anomaly, such as cleft lip, cleft palate, or both; that equals approximately 0.2 percent of births, or approximately 37 per year. However, while the incidence of orofacial anomalies is relatively low, a significant number of children who have the birth defect—approximately 90 percent—will need orthodontic services, defined in HB No. 2522 as direct or consultative services by a licensed orthodontist. The DOH Children with Special Health Needs Branch reports that 33 percent, or 48, of the 144 children in its program have had orthodontic treatment for their orofacial anomalies. The Kapi‘olani Cleft Center reports that 36 percent of its 471 active patients—a total of approximately 170 children—have received orthodontic services as part of treatment; however, that number is likely to grow larger as more patients are treated. The Kapi‘olani Cleft Center has a total of 624 active and inactive patients and expects 92 percent of them, or approximately 574, will need orthodontic services at some point. Likewise, Kaiser reports it treats approximately 15–20 patients a year for orofacial anomalies and estimates 90 percent of them have undergone orthodontic treatment.

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

Children with orofacial anomalies appear generally able to receive orthodontic treatment coordinated by the DOH Children with Special Health Needs Branch for families enrolled in the Children with Special Health Needs Program (CSHNP), the Kapi‘olani Cleft Center, and Kaiser, but this treatment is limited. HMAA says it would cover medically necessary orthodontic treatment for patients with orofacial anomalies, but reported covering no such treatment at least since January 2013. UHA has provided no orthodontic treatment for the five orofacial anomaly patients of which it is aware. HMSA says the patient would have to pay for orthodontic treatment since it is not a covered benefit. While the CSHNP provides service coordination to families without regard to income, in order to receive limited financial assistance, families must meet the program’s financial criteria (267 percent Federal Poverty Guidelines). Families with private insurance who do not qualify for

financial assistance under the statewide program would have to seek a grant from the Kapi‘olani Cleft Center or pay out of pocket. The Kapi‘olani Cleft Center said patients may be denied coverage from medical insurers because orthodontic treatment for orofacial anomalies is considered a cosmetic procedure; as a result, persons needing services provided by a licensed orthodontist for medical reasons often pay out of pocket or obtain grants from the Kapi‘olani Cleft Center.

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

The lack of insurance coverage for medically necessary orthodontic services for orofacial anomalies places a significant hardship on families that cannot receive grants or qualify for state assistance through the DOH’s CSHNP. Treatment cost estimates range from approximately \$5,700 to \$20,000, and up. In testimony to the 2014 Legislature, families facing such expenses for treatment said they pose a significant hardship, particularly for orthodontia treatment that is medically necessary to progress from one surgery to another procedure. One such parent, a public school teacher, testified that the family simply could not afford to pay out of pocket and said it is unfair that the treatment would be covered by Med-QUEST, but not the family’s private insurer. The DOH says mandatory coverage would ease the financial burden and hardship facing 44 families enrolled in the DOH CSHNP with commercial health plans.

4. The level of public demand for individual or group insurance coverage of the treatment or service

Demand for individual or group insurance coverage for medically necessary orthodontic services for orofacial anomalies does not appear high among the general public; however, demand is high among families with children born with the defect, as well as public health and medical organizations. The 2014 Legislature received testimony from 22 organizations and individuals supporting mandatory coverage of orthodontic treatment for orofacial anomalies. Among them were Kaiser, the Hawai‘i Dental Association, and Hawai‘i Pacific Health, as well as a number of families. The Kapi‘olani Cleft Center indicated there has been enough interest to allow it to establish a grant program; however, the level of funding is insufficient to ensure the grant fund’s long-term sustainability. Most of the organizations we surveyed that

provide coverage or financial support to pay for treatments, excluding HMAA and UHA, have received requests for coverage. HMSA said it had received “a few” inquiries about coverage for orthodontic treatment but did not know whether these were for medically necessary orthodontic treatment.

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

The level of interest among collective bargaining organizations is largely unknown, but probably low. We received responses from only four of 17 public and private unions to which we sent surveys: the Hawai‘i Government Employees Association (HGEA), UNITE HERE, the International Longshore and Warehouse Union (ILWU), and the University of Hawai‘i Professional Assembly (UHPA). Of those four, UNITE HERE, the ILWU, and the UHPA said they had not received or were not aware of requests from members expressing an interest to include medically necessary orthodontic treatment when negotiating privately for coverage in group health insurance policies. HGEA did not respond to the question.

6. The impact of providing coverage for the treatment or service (such as morbidity, mortality, quality of care, change in practice patterns, provider competition, or related items)

Mandating health insurance coverage for orthodontic services for treating orofacial anomalies as defined in HB No. 2522 may lead to better health outcomes for children. Kaiser reported that the social impact of providing insurance coverage would be “[i]mproved dental health, physical appearance, and social presentation.” The DOH Children with Special Health Needs Branch said that timely orthodontic treatment could help preserve and stabilize teeth next to the cleft site; improve functional outcomes for chewing, biting, and speech; and lessen the social-emotional impact to a child related to visible differences with other children.

According to the Kapi‘olani Cleft Center, mandating insurance coverage can help ensure that doctors provide care—including orthodontic treatment and coordinated surgery—at the optimal time for best results. For those with a cleft palate, delays in orthodontic treatment and subsequent bone graft surgery can cause a decrease in successful bony bridging of the graft site. Moreover, lengthy delays in needed bone grafts also may potentially cause loss of teeth next to a cleft site and decrease the success rate of a bone graft. Orthodontic treatment before bone graft surgery helps to correctly expand the upper jaw so a surgeon can have better access to the cleft site, which would affect

eruption of permanent teeth into the cleft site, provide support to the lip and nose, provide stability to the upper jaw, and close the hole between the mouth and the nose. Treatment delays also may potentially affect a patient's self-perception, social integration, employability, and overall productivity.

Although Kaiser said the social impact would be better health outcomes, two other insurers indicated the mandatory insurance coverage would produce negative social impacts. HMAA reported that "from a financial perspective" there was the potential that more patients would use orthodontic treatment for orofacial anomalies, which would lead to higher premium costs, and a potential increase in costs for orthodontic treatments because consumerism would be removed from decision-making. UHA said there would be an increase in costs and a potential for patients gaming the system.

7. The impact of any other indirect costs upon the costs and benefits of coverage as may be directed by the legislature or deemed necessary by the auditor in order to carry out the intent of this section

Based on responses from insurers, indirect costs may increase as the result of mandating coverage. HMAA and HMSA cited additional administrative costs. HMAA also predicted labor costs for precertification requirements would be incurred and the pricing of orthodontic services would increase. HMSA said it would incur additional costs to train staff, update information systems, and create a provider network. UHA said it would incur additional costs associated with authorization and oversight in a field in which "healthcare insurers have no expertise." These increased costs may result in higher premiums.

Despite these predicted increases, the Kapi'olani Cleft Center said there might be an indirect benefit on costs, as treatment may lead to fewer clinic visits and a decrease in the number of surgeries for revisions if there is a failure, and thus lower treatment costs. The center indicated indirect cost reductions could offset cost increases.

Financial impacts on insurers are minimal

Results of our survey indicated that the financial impacts would be minimal, as discussed below.

1. The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service

Insurance coverage as proposed in HB No. 2522 would likely decrease the cost to orofacial anomaly patients while shifting this cost to the

health insurers. However, the amount of additional costs insurers would bear is unclear. The Kapi‘olani Cleft Center concluded that the shift in costs to insurers would be minimal because relatively few of its patients—14 percent, or 67—would be affected. HMSA and Kaiser both said coverage would shift costs from patients to the health plan, but the amount of this cost shift is not clear. HMSA reported the cost for orthodontic treatment would decrease by the benefit amount paid by the medical insurer; however, Kaiser said the amount is unknown. HMAA concurred that the amount is “unknown on an individual basis,” although HMAA asserted that as prices for orthodontic services increase because of coverage, insurers as a whole would pay more. The DOH and Kapi‘olani Cleft Center concurred that coverage would decrease costs to families; while DOH said that savings would be “significant,” the Kapi‘olani Cleft Center said insurance coverage would save families \$2,000–\$2,900 for the first treatment phase and \$5,000–\$5,900 for the second and third treatment phases.

2. The extent to which the proposed coverage might increase the use of the treatment or service

Insurance coverage for medically necessary orthodontic services for orofacial anomalies as proposed in HB No. 2522 appears unlikely to increase the use of direct or consultative services by a licensed orthodontist as prescribed by a craniofacial team. Kaiser said it believes its current orofacial anomaly patients needing orthodontic treatment are already accessing it and that there would not be many additional patients seeking orthodontic treatment for orofacial anomalies. The Kapi‘olani Cleft Center concurred that usage will not increase because those who need medically necessary orthodontics now pay for the procedure with grants or pay out of pocket. HMAA, HMSA, and UHA said the potential increase in use of the treatment was not known or impossible to predict; however, UHA predicted there would be an increase due to a proliferation of diagnoses and “pseudo diagnoses.”

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

The Kapi‘olani Cleft Center said there have been some instances where orthodontics put teeth into alignment and replaced the need for surgery; however, the center indicated that orthodontics would not be an alternative to the need for all orofacial surgery, and whether it could serve as an alternative would depend on the severity of the condition and the recommendation of the craniofacial team. Three of four insurers provided no information on how orthodontic services might serve as an alternative for more expensive treatment for orofacial anomalies. Kaiser said medically necessary orthodontic treatment would not serve

as an alternative for more expensive procedures. Similarly, the DOH's Children with Special Health Needs Branch asserted that orthodontic treatment is the standard of care for orofacial anomalies and that there is thus no alternative.

4. The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policy holders

Three insurers (HMAA, HMSA, Kaiser) could not say whether coverage will increase or decrease insurance premiums. UHA reported premiums and costs would increase but could not provide estimates. DOH cited reports from California and Massachusetts indicating that mandated insurance coverage for orofacial anomalies increased premiums by two cents to four cents per member, per month, or less; however, Hawai'i's insurance premium cost increases are unknown since HMAA, HMSA, and Kaiser are unable to provide any estimates without more detailed analysis.

5. The impact of this coverage on the total cost of health care

The total cost of healthcare is likely to stay the same since insurance coverage is not expected to increase the use and cost of treatment. UHA offered no basis or details but said costs would increase. HMAA, HMSA, and Kaiser said the effect on total costs is unknown or could not be estimated. Kapi'olani Cleft Center said costs may decline due to a decrease in the need for additional surgeries and other treatments, but like UHA provided no basis or details.

Sixteen States Mandate Health Insurance Coverage Similar To Proposed House Bill No. 2522

States vary on the scope of coverage they require insurers to provide. Some states mandate coverage only for orthodontic treatment of cleft lip, cleft palate, or both; other states requires coverage for a range of craniofacial disorders. Age limitations further define the scope of coverage in some states, while others do not specify an age limit. No state establishes a dollar amount as a maximum benefit, as Hawai'i's proposed law would do, which makes limitations of \$5,000 per treatment phase as proposed in HB No. 2522 unique. Exhibit 2.2 describes the mandates in other states.

Exhibit 2.2
Mandated Coverage in Other States

State	Coverage Mandated
1. Arkansas	Dental care for a person of any age who is diagnosed with a craniofacial anomaly if the treatment is medically necessary to improve a functional impairment.
2. California	Medically necessary orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Excludes cosmetic surgery to “alter or reshape normal structures of the body in order to improve appearance.” No age limit stated.
3. Colorado	Medically necessary orthodontic treatment for children born with cleft lip or cleft palate or both. Orthodontic treatment for cleft palate to be covered by dental policy if dental policy is in effect at the time of birth. Statute mandates that there is no age limit.
4. Connecticut	Medically necessary orthodontic processes and appliances for the treatment of craniofacial disorders for persons 18 years old or younger. Requires coverage only if team recognized by the American Cleft Palate-Craniofacial Association diagnoses condition and prescribes treatment.
5. Florida	Dental treatment of cleft lip and cleft palate for children under 18 years old. Treating physician or surgeon must certify that the treatment is medically necessary and consequent to treatment of the cleft lip or cleft palate. Excludes coverage for care or treatment of teeth or gums or cosmetic surgery.
6. Indiana	Orthodontic treatment involved in managing cleft lip and cleft palate for newly born children.
7. Louisiana	Orthodontic treatment and management of cleft lip and cleft palate. No age limit specified.
8. Maryland	Expenses arising from orthodontics involved in managing cleft lip or cleft palate or both. No age limit specified.
9. Massachusetts	Orthodontic treatment and management for treating cleft lip and cleft palate for children under 18 years old. Services must be prescribed by the treating physician or surgeon who certifies that the services are medically necessary and consequent to the treatment of the cleft lip, cleft palate, or both. Excludes coverage for treatment not related to managing congenital conditions of cleft lip and cleft palate.

State	Coverage Mandated
10. Minnesota	Orthodontic treatment of cleft lip and cleft palate for dependent children from newly born to 19 years old. Excludes payment for orthodontic procedures not related to cleft lip and cleft palate treatment.
11. North Carolina	All necessary treatment and care needed by individuals born with cleft lip or cleft palate. Benefit limited to minor children.
12. Oregon	Orthodontic services for the treatment of craniofacial anomalies if the services are medically necessary to restore function. "Craniofacial anomaly" is defined as a physical disorder identifiable at birth that affects the bony structures of the face or head, including but not limited to cleft palate, cleft lip, craniosynostosis, craniofacial microsomia, and Treacher Collins syndrome. ² Excludes coverage for developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; or temporomandibular joint disorder. ³
13. South Carolina	Orthodontics medically necessary for the care and treatment of cleft lip and palate. No age limit specified.
14. Vermont	Medically necessary, surgical or non-surgical treatment of musculoskeletal disorder ⁴ affecting any bone or joint in the face, neck, or head caused by congenital defect. Treatment must be prescribed or administered by physician or dentist. Excludes coverage for dental services for the diagnosis or treatment of dental disorders or dental pathology. No age limit specified.
15. Virginia	Orthodontic services that is medically necessary for the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia. Designated for newborn children.
16. Wisconsin	Treatment of newborn infants for congenital defects and birth abnormalities requiring repair or restoration of any body part when necessary to achieve normal body functioning. Excludes cosmetic surgery performed only to improve appearance.

Source: Office of the Auditor

² Craniosynostosis is a premature fusion of the plates of the skull. Microsomia is an abnormal smallness of the body. Treacher Collins syndrome refers to a defective formation of the face and jaw.

³ Malocclusion means an abnormality in the coming together of the teeth. The temporomandibular joint (TMJ) connects the jaw to the side of the head and enables persons to talk, chew, and yawn.

⁴ Musculoskeletal disorder involves both musculature and skeleton.

Hawai‘i’s limitations to coverage are unique

Based on disorders covered nationally, Hawai‘i’s HB No. 2522 would be among the more inclusive. Of the 16 states mandating coverage, ten limit the coverage to orthodontic treatment for cleft lip or cleft palate or both, while an eleventh state limits coverage to treatment of cleft lip, cleft palate, and ectodermal dysplasia.⁵

In contrast, HB No. 2522—like mandates in five other states—would provide broader coverage. Specifically, HB No. 2522 would require insurers to cover medically necessary orthodontic services for the treatment of “orofacial anomalies,” which the measure defines as “cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.” Similar to HB No. 2522, laws in Arkansas, Connecticut, and Oregon mandate orthodontic coverage for “craniofacial” anomalies or disorders not limited to cleft lip and cleft palate. Vermont requires coverage of medically necessary treatment for a musculoskeletal disorder that affects any bone or joint in the face, neck, or head caused by congenital defect. Wisconsin requires insurers to cover newborn infants for treatment of congenital defects and birth abnormalities requiring repair or restoration of “any body part when necessary to achieve normal body functioning.”

States also vary on age limits. Like Hawai‘i, where coverage proposed in HB No. 2522 is limited to persons 26 years old or younger, eight of 16 states with mandates place age limits on coverage. Most of these laws—in Connecticut, Florida, Massachusetts, Minnesota, and North Carolina—limit coverage to minors, with age limits set at 18 or 19 years old. The other three states—Indiana, Virginia, and Wisconsin—designate coverage as a benefit for newly born children but otherwise specify no age limits. Seven states do not specify an age limitation. Colorado is the only state to stipulate that there be no age limit on benefits.

In addition to age limits, states limit coverage by requiring the orthodontic treatment be necessary to treat a functional birth defect and not for cosmetic purposes. Hawai‘i’s proposed measure is consistent with the vast majority of states (13 of 16), which limit the benefit by requiring the orthodontic treatment be medically necessary to treat the defined disorder. California, Connecticut, Florida, and Wisconsin specifically exclude cosmetic procedures.

Although similar to laws of other states in the above ways, HB No. 2522 is unique in establishing a maximum benefit, which is \$5,000 per treatment phase. No other state has such a dollar-amount limit. The DOH Children with Special Health Needs Branch suggested increasing this maximum to \$5,500 to better reflect average costs of treatment.

⁵ Ectodermal dysplasia is a group of conditions in which there is abnormal development of the skin, hair, nails, teeth, or sweat glands.

***Other changes to
HB No. 2522 sought by
insurers***

While we did not find flaws in HB No. 2522, some insurers raised concerns about the measure as drafted. UHA, for example, could foresee as problematic the use of the broad term “orofacial anomaly,” which could cover a host of diagnoses, including some that UHA said may produce only mild degrees of abnormality. UHA did not suggest any recommendations for changes to the bill, but it posed a question: “Who will draw the line when so many possible diagnoses can be placed under ‘orofacial anomaly?’” We found, however, that HB No. 2522 narrowly defines treatment for orofacial anomalies as “care prescribed for an individual diagnosed with an orofacial anomaly by a craniofacial team that includes a licensed dentist, orthodontist, oral surgeon, and physician, and is coordinated between specialists and providers.”

HMSA also questioned the use of the broad term. HMSA said the measure could inadvertently mandate coverage for services beyond those that are medically necessary and allow patients to seek multiple orthodontia episodes in pursuit of a better cosmetic outcome. While HMSA recognized that HB No. 2522 attempts to limit coverage to orthodontic services that are medically necessary, the problem occurs with post-surgical orthodontia when the individual undergoes several procedures to achieve an acceptable cosmetic result. Therefore, for clarity, HMSA suggested limiting the benefit to children with cleft lip and cleft palate, and to one medically necessary orthodontic service needed to prepare a child for surgery and one medically necessary orthodontic episode after corrective surgery is completed.

Conclusion

House Bill No. 2522 would mitigate a significant financial hardship for working families whose private medical insurance does not cover medically necessary orthodontic services for their children born with orofacial anomalies. This includes cleft lip or palate or other birth defects of the mouth and face affecting functions such as eating, chewing, speech and respiration. For example, according to the Kapi‘olani Cleft Center, insurance coverage would save families \$2,000–\$2,900 for the first treatment phase and \$5,000–\$5,900 for the second and third treatment phases. The proposed bill shifts these out-of-pocket costs by requiring health insurers to provide coverage for direct or consultative services by a licensed orthodontist, similar to helping families enrolled in programs administered by the Med-QUEST Division of the Department of Human Services.

We found medically necessary orthodontic treatment for orofacial anomalies is not used by a significant portion of the general population. That usage is not likely to increase if the measure is passed because children requiring the services of an orthodontist to treat orofacial anomalies generally obtain the services, albeit delayed until issues

of payment are resolved. Overall treatment costs also are unlikely to increase. Although the measure is expected to increase administrative and other indirect costs, the precise impact on insurance premiums is unknown. Nevertheless, the proposed bill would provide a substantial social benefit in exchange for a minimal cost to private insurers.

Recommendation

House Bill No. 2522 requiring health insurance coverage for medically necessary orthodontic treatment for orofacial anomalies should be enacted.

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Responses of the Affected Agencies

Comments on Agency Responses

On September 4, 2014, we transmitted a draft of this report to the Departments of Health (DOH) and Commerce and Consumer Affairs (DCCA). A copy of the transmittal letter to the DOH is included as Attachment 1. A similar letter was sent to DCCA. The departments opted not to respond.

ATTACHMENT 1

**STATE OF HAWAII
OFFICE OF THE AUDITOR**

465 S. King Street, Room 500
Honolulu, Hawai'i 96813-2917



JAN K. YAMANE
Acting State Auditor

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September 4, 2014

COPY

The Honorable Linda M. Rosen, M.D., M.P.H.
Director
Department of Health
Kīna'u Hale
1250 Punchbowl Street
Honolulu, Hawai'i 96813

Dear Dr. Rosen:

Enclosed for your information are three copies, numbered 6 to 8, of our confidential draft report, *Mandatory Health Insurance for Treatment of Orofacial Anomalies*. We ask that you telephone us by Monday, September 8, 2014, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit your hard copy response to our office no later than 4:30 p.m., Thursday, September 11, 2014.

The Department of Commerce and Consumer Affairs, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this confidential 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,

for Jan K. Yamane
Acting State Auditor

Enclosures