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Primer on State Statutory Mandates of Third-Party Orthodontic Coverage for Cleft Palate and Craniofacial Care in the United States

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Abstract

Provision and timing of orthodontic treatment is a crucial part of comprehensive cleft palate and craniofacial care. Some states statutorily mandate orthodontic coverage for the medically necessary care of cleft palate and craniofacial anomalies. However, application of the medically necessary standard varies broadly. Disputes over medical necessity lead to orthodontic coverage denials and surgical intervention delays. Provider-friendly statutory definitions of medical necessity enable patients and providers to avoid such hurdles. The objective of this study is to evaluate state mandates and highlight language favorable to patients and providers.

Keywords

cleft lip; cleft palate; craniofacial; orthodontics; third-party coverage; insurance

Introduction

Orthodontics has been a critical component of the multidisciplinary cleft palate and craniofacial team since the first team was established in the late 1930s (Long, 2009). The American Cleft Palate-Craniofacial Association (ACPA), which sets national standards for the modern cleft palate and craniofacial team, designates orthodontics, together with speech-pathology and plastic surgery, as one of 3 core specialties whose participation is a prerequisite to being an ACPA-approved team (American Cleft Palate-Craniofacial Association, 2016). Orthodontic care of patients with cleft palate and/or craniofacial

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Supplemental Material

Supplementary material for this article is available online.

anomalies may include dentition alignment, palate expansion, malocclusion correction, and preoperative treatment. These treatments are not only integral to establish or restore function, they lend necessary support to the goals of other team specialties by aiding in articulation, enunciation, eating, social confidence, and preparation for surgical reconstruction.

Despite the importance of orthodontics for complete and adequate habilitation, third-party payers often deny coverage for orthodontic care of cleft palate and craniofacial patients on the basis such procedures are cosmetic or medically unnecessary (Strauss, 1999). In response to this issue, the United States Congress, as well as some states' legislatures, have sought to statutorily mandate coverage for care of patients with cleft palate and craniofacial anomalies, to varying success. These efforts have resulted in a checkered legal landscape of divergent state laws and thin federal guidelines, leaving patients in many states to grapple with coverage denials and impeded access to care.

At the federal level, legislative efforts have either stalled entirely or been diluted by subsequent administrative rulings. The Reconstructive Surgery Act, which was introduced in the U.S. House of Representatives in 2007, proposed mandated coverage of medically necessary preoperative care, post-operative care, and reconstructive surgery of patients with congenital defects; the bill never left the committee (Reconstructive Surgery Act, 2007). More recently, the Senate and the House of Representatives each introduced a version of the Children's Access to Reconstructive Evaluation & Surgery (CARES) Act in 2007 (CARES Act, 2007a, 2007b). This bill, unsuccessful in 2007 and again in both 2009 and 2011 after being reintroduced, sought to require coverage for outpatient and inpatient treatment of minors' congenital or developmental deformities or disorders (CARES Act, 2007a, 2007b, 2009a, 2009b, 2011a, 2011b). None of the bills have since been reintroduced, nor did any explicitly extend to orthodontia.

There still exists no federal coverage mandate for orthodontic treatment of cleft palate and/or craniofacial anomalies, and the federal Patient Protection and Affordable Care Act (the "Affordable Care Act") did not close this gap. The Affordable Care Act, enacted in 2010, provides only minimal guidance on general pediatric orthodontic coverage. The Affordable Care Act requires any health insurance sold in the private market or on any state exchange to offer coverage of certain essential health benefits (Patient Protection and Affordable Care Act, 2010). Oral care services of children under age 19 comprise one of 10 Essential Health Benefits required by the Affordable Care Act (Patient Protection and Affordable Care Act, 2010). However, the Affordable Care Act made an exception to this for plans sold on state exchanges (Patient Protection and Affordable Care Act, 2010). Plans sold on state exchanges need not offer the pediatric dental Essential Health Benefit, as long as standalone dental plans offering pediatric dental coverage are also available on the exchange (Patient Protection and Affordable Care Act, 2010). Employers and individual insureds purchasing coverage on the exchange are not required to purchase the standalone coverage, even when electing not to leave children uninsured for dental care. The Department of Health and Human Services, the federal agency that administers the Affordable Care Act, issued a Final Rule extending part of the standalone dental plan carve-out to the private market (Department of Health and Human Services, 2013). However, the carve-out still requires

private insurers to include the pediatric dental Essential Health Benefit in an offered plan absent reasonable assurance that the insured obtained adequate pediatric dental coverage through another plan (Department of Health and Human Services, 2013).

Nevertheless, even when health insurance and standalone dental plans do offer the pediatric dental Essential Health Benefit, the extent to which the pediatric dental Essential Health Benefit requires orthodontic care is only hazily addressed by federal law. The Department of Health and Human Services construes the term oral care to extend to orthodontic care only when such care is medically necessary (Department of Health and Human Services, 2013). The federal government does not define what qualifies as medically necessary orthodontic care.

The Affordable Care Act explicitly leaves the choice of whether to mandate additional coverage to state legislatures (Patient Protection and Affordable Care Act, 2010). The federal government's deference to state law on issues related to pediatric orthodontic care, coupled with the Affordable Care Act pediatric dental carve-outs, has left the issue of pediatric orthodontic coverage, including for patients with cleft palate and craniofacial anomalies, in the purview of state law, where it was pre-Affordable Care Act.

The purpose of this article is to survey state statutes regarding mandatory insurance coverage for craniofacial care and give providers and advocates an up-to-date understanding of the coverage mandates across the country. The paper also will highlight statutory provisions that are most favorable to patients and providers.

Methods

Open access legal research databases, including LexisNexis, Justia, FindLaw, and state legislature websites, were used to identify statutory coverage mandates for cleft palate and craniofacial care. Search terms to locate statutes were *cleft*, *craniofacial*, *orofacial*, *congenital*, *orthodontic*, and *orthodontia*. Statutes were analyzed and tabulated for extent of orthodontic coverage, exclusions, limits, effective or enacted date, and legal standard. (See Appendix 1.) Narrow coverage mandates for newborns with unspecified congenital anomalies were excluded. The excluded mandates merely require the insurance policy of the parent to extend to their newly born child, such that the dependent child may be added to the policy after their birth.

Results

Eighteen states statutorily mandate some type of coverage of cleft palate and/or craniofacial anomalies. Four states (CT, HI, MA, VT) explicitly mandate orthodontic coverage and allow providers, including ACPA-approved teams, to determine medical necessity. Two states (AR, FL) do not explicitly mandate orthodontic coverage but include broad language that can encompass orthodontia and allow providers to determine medical necessity. Nine states mandate orthodontic coverage but either do not define the specified legal standard (CA, CO, OR, SC, VA) or do not specify a legal standard (IN, LA, MD, MN). Two states (NC, WI) do not explicitly mandate orthodontic coverage but mandate some cleft palate and/or

craniofacial care without defining the legal standard. One state (TX) only mandates craniofacial reconstructive surgery. (See Figure 1.)

Specified legal standard qualifiers include “medically necessary” (AR, CO, CT, FL, HI, MA, SC, VT, VA), “medically necessary and an integral part of reconstructive surgery” (CA), “medically necessary to restore function” (OR), “necessary” (NC), and “necessary to achieve normal body functioning” (WI). The definition and application of these qualifiers vary broadly from state to state.

Age limitations range from “any age” (AR, CO), “under 26” (HI), “18 or younger” (CT), “initiate/schedule before 18” (MN), “under 18” (FL, MA, TX), to “newborn” (IN, NC, VA, WI), or are unspecified (SC, VT, CA, LA, MD, OR). One state (HI) limits cost (\$5,500/treatment phase). Enacted and effective dates vary widely (1976–2015).

Ten of the 18 states impose additional exclusions or requirements (CA, CT, IN, MA, MN, OR, SC, VT, VA, WI), such as excluding cosmesis or unrelated care (CA, CT, MA, MN, WI), requiring newborns be added to a policy shortly after birth (IN, VA), or specifying that any standalone dental policy in place will be primary (MN, SC). California allows coverage denials if: there is another more appropriate procedure, the procedure will offer only minimal improvement in appearance, or prior approval is not obtained. Oregon excludes treatment of temporomandibular joint disorders or developmental maxillofacial conditions resulting in overbite, crossbite, malocclusion, or similar irregularities. Vermont excludes coverage for dental disorders or pathology of the gums, teeth, or alveolar ridge.

States also vary in breadth of conditions covered by the statutes. Five states only mandate coverage for the treatment of cleft lip and cleft palate (FL, MD, MA, MN, NC). Two states mandate coverage for cleft lip, cleft palate, and related (CO, SC) or secondary (LA) conditions. Ten states explicitly extend coverage to the treatment of craniofacial anomalies (AR, CA, CT, HI, IN, OR, TX, VT, VA, WI).

Thirty-two states do not mandate coverage.

Discussion

Of the 18 states mandating coverage of cleft palate and/or craniofacial anomalies, 11 specify a legal standard for coverage (CT, HI, MA, VT, AR, FL, CA, CO, OR, SC, VA). Every state statute designating a legal standard adheres to either the “medically necessary” standard, or a closely related standard. These “medically necessary”-type qualifiers are problematic. The absence of additional language defining what constitutes medical necessity creates a burdensome landscape for parents and providers to navigate in determining extent of coverage for patients with cleft palate and/or craniofacial anomalies. For example, the American Association of Orthodontics, in an effort to establish a universal definition of “medically necessary orthodontic care,” interviewed a cross-section of representatives from third-party insurance providers about their definitions of the term (American Association of Orthodontics, 2016). Each insurance provider had a unique definition of what qualified for coverage.

This lack of standardization in coverage determination across the insurance industry makes it difficult to predict insurance coverage, creating the need for patients and providers to await final determinations of coverage before proceeding with care. Resources may also be wasted by patients and providers on time spent appealing insurance decisions. Disputes over medical necessity can therefore lead to orthodontic coverage denials and subsequent surgical intervention delays (State of Hawai'i Auditor, 2016). In response to this problem, the American Association of Oral and Maxillofacial Surgeons has also recognized the need for standardization, and has issued a white paper in support of legislation requiring broad orthodontic care coverage for craniofacial patients until they reach the age of 26 (American Association of Oral and Maxillofacial Surgeons, 2016).

Consistent statutory language favorable to providers could enable patients to avoid coverage denials and treatment delays. Favorable statutes provide explicit definitions of medical necessity by deferring to provider or team determinations of necessity. Six states' statutes mandating third-party coverage of orthodontic care for patients with cleft palate and/or craniofacial anomalies have enacted these provider-friendly statutes (AR, CT, FL, HI, MA, VT).

Because of limitations unique to each of the 6 provider-friendly statutes, none of the statutes stand out as the most broad or most favorable. For example, neither Arkansas nor Florida explicitly mandate orthodontic coverage, though the coverage is likely encompassed by broad statutory language. Connecticut only mandates coverage for patients 18 or younger. Massachusetts and Florida only mandate coverage for patients under 18 and do not explicitly extend the mandate to patients with craniofacial anomalies other than cleft lip and/or cleft palate. Hawaii extends coverage only to patients under 26 and limits mandatory coverage to \$5500 per treatment phase. Vermont excludes from its mandate dental services for the diagnosis or treatment of dental disorders or pathology of the gums, teeth, or alveolar ridge.

An ideal state or federal statute would provide explicit mandatory coverage for the medically necessary treatment of orthodontic care for patients of any age with cleft palate and/or craniofacial anomalies, would not include a maximum benefit limit or additional exclusions, and would define "medically necessary" to mean prescribed by a physician, dentist, or surgeon, or by an ACPA-approved team. A federal statute would provide much needed consistency on a national scale.

This paper is limited in that it does not evaluate the extent these statutes apply to specific types of insurance contracts, including various types of managed care contracts or selfinsured group health care (Strauss, 1999). It also does not examine state judicial or administrative interpretation of the statutes themselves. An analysis of those interpretations on open access legal research databases would be unreliable and incomplete, because of limitations of the databases. Nevertheless, evaluating such interpretations is important to understanding the breadth of each specific statute. One reason for this is some state agencies, through policies, rules, and regulations, may interpret existing laws, including the narrow coverage mandates for newborns excluded by this study, to extend to orthodontic care of patients with cleft palate and/or craniofacial anomalies. Oklahoma is an example of such a state. The Oklahoma Code requires coverage for the necessary care and treatment of

newborns with congenital defects and birth anomalies, without further specification (Okla. Stat., 2015). However, Oklahoma has since promulgated an administrative rule interpreting that provision of the Oklahoma Code to require coverage for inpatient and outpatient care of patients with cleft lip or cleft palate, specifically orthodontics (Okla. Admin. Code, 2016). Therefore, state mandates may be broader than the statutes reflect.

The paper also does not examine the other ways states provide patients with access to cleft palate and/or craniofacial care, including state-level requirements of pediatric dental as an Essential Health Benefit or state social insurance programs. Finally, analysis of proposed bills at the state level and an examination of why certain bills failed and others succeeded would be useful to strategically coordinate advocacy.

Conclusion

State mandated orthodontic coverage varies in breadth. By deferring to provider determinations of medical necessity, 6 of the states mandating third-party coverage of orthodontic care for patients with cleft palate and/or craniofacial anomalies (AR, CT, FL, HI, MA, VT) have enacted statutory language that is particularly favorable to patients and providers. Allowing providers to determine medical necessity, using treatment protocols recognized as standard of care, can minimize coverage denials for the necessary orthodontic care of patients with cleft palate and/or craniofacial anomalies.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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