



# House of Representatives

General Assembly

**File No. 233**

January Session, 2011

Substitute House Bill No. 5438

*House of Representatives, March 28, 2011*

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## ***AN ACT LIMITING COPAYMENTS FOR CHIROPRACTIC SERVICES.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-507 of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective January 1, 2012*):

3 [Every] (a) Each individual health insurance policy delivered, issued  
4 for delivery, [or] renewed, amended or continued in this state [on or  
5 after October 1, 1989,] shall provide coverage for services rendered by  
6 a chiropractor licensed under chapter 372 to the same extent coverage  
7 is provided for services rendered by a physician, if such chiropractic  
8 services (1) treat a condition covered under such policy, and (2) are  
9 within those services a chiropractor is licensed to perform.

10 (b) No such policy shall impose a copayment greater than fifty per  
11 cent of the total cost of any single chiropractic service covered under  
12 subsection (a) of this section.

13 Sec. 2. Section 38a-534 of the general statutes is repealed and the

14 following is substituted in lieu thereof (*Effective January 1, 2012*):

15 [Every] (a) Each group health insurance policy providing coverage  
16 of the type specified in subdivisions (1), (2), (4), (6) and (11) of section  
17 38a-469, delivered, issued for delivery, [or] renewed, amended or  
18 continued in this state [on or after October 1, 1989,] shall provide  
19 coverage for services rendered by a chiropractor licensed under  
20 chapter 372 to the same extent coverage is provided for services  
21 rendered by a physician, if such chiropractic services (1) treat a  
22 condition covered under such policy, and (2) are within those services  
23 a chiropractor is licensed to perform.

24 (b) No such policy shall impose a copayment greater than fifty per  
25 cent of the total cost of any single chiropractic service covered under  
26 subsection (a) of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2012</i>	38a-507
Sec. 2	<i>January 1, 2012</i>	38a-534

**INS**      *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

**OFA Fiscal Note**

**State Impact:** None, See below for out years impact

**Municipal Impact:**

Municipalities	Effect	FY 12 \$	FY 13 \$
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

**Explanation**

The bills provisions are not anticipated to result in a fiscal impact to the state employee health plan. The state health plan currently provides coverage for in-network chiropractic visits with a standard office-visit co-pay of \$10-\$15. Medically necessary chiropractic procedures received in-network are covered with no co-pay. The state Point of Service Plan (POS) currently requires a 20% copayment for out-of-network chiropractic procedures, and the state Point of Entry Plan (POE) does not cover this benefit out-of-network.

The bill prohibits imposing a copayment or cost-sharing in excess of 50% of the cost of the procedure; however it does not require out-of-network coverage of these services. Therefore the mandate would not require the POE plans to begin offering this benefit out-of-network.

The bill's provisions may increase costs to certain fully insured municipal plans which require copayments for chiropractic procedures in excess of 50% of the cost of a procedure<sup>1</sup>. The coverage requirements may result in increased premium costs when

<sup>1</sup> The estimated average annual cost of treating back pain is \$2,431 per patient. (Connecticut Mandated Health Insurance Benefits Report, University of Connecticut, Vol. III, p. 177).

municipalities enter into new health insurance contracts after January 1, 2012. The bill does not make changes to coverage currently required. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The many municipal health plans are recognized as “grandfathered” health plans under the PPACA. It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of the state employee health plan or grandfathered municipal plans PPACA<sup>2</sup>.

### ***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

The federal health care reform act requires that, effective January 1, 2014; all states must establish a health benefit exchange, which will offer qualified plans that must include a federally defined essential benefits package. While states are allowed to mandate benefits in excess of the basic package, the federal law appears to require the state to pay the cost of any such additional mandated benefits. The extent of these costs will depend on the mandates included in the federal essential benefit package, which have not yet been determined. However, neither the agency nor mechanism for the state to pay these costs has been established.

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<sup>2</sup> According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. ([www.healthcare.gov](http://www.healthcare.gov))

**OLR Bill Analysis****sHB 5438****AN ACT LIMITING COPAYMENTS FOR CHIROPRACTIC SERVICES.****SUMMARY:**

This bill prohibits certain health insurance policies from imposing a copayment on a covered chiropractic service that is greater than 50% of the total cost of the service. It applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut.

By law, certain health insurance policies must provide coverage for chiropractic services to the same extent as coverage for physician services if the chiropractic services treat a covered condition and are within the scope of the chiropractor's license. The law applies to individual and group health insurance policies delivered, issued, or renewed in Connecticut. The bill also applies the requirement to policies amended or continued in the state.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2012

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 15 Nay 5 (03/15/2011)