OFFICE OF FISCAL ANALYSIS

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SB-15
AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR MOTORIZED WHEELCHAIRS.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 20 $	FY 21 $
State (ACA Mandate)	Potential Cost	See Below	See Below

Municipal Impact:

Municipalities	Effect	FY 20 $	FY 21 $
Various Municipalities	STATE MANDATE[1] - Cost	See Below	See Below

Explanation

The bill does not result in a cost to the state employee and retiree health plan as the plan currently provides coverage for wheelchairs under the durable medical equipment (DME) benefit at 100% for in-network and 20% coinsurance for out-of-network. Prior Authorization is required for wheelchairs or repairs costing in excess of $500. In calendar year 2018, the state employee and retiree health plan spent approximately $250,000 on wheel chairs and repairs.

There will be an impact to fully-insured municipal plans that do not provide the coverage required in the bill. The impact will be reflected in premiums for policy years beginning on and after January 1, 2020.

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

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Based on industry data, the cost for manual wheel chairs can range from $500 - $2,000 and the cost for motorized wheel chairs can range from $1,200 to an average of approximately $7,000. Batteries and replacement parts for motorized wheelchairs range from $70 to $500 depending on the chair.[2] Pursuant to federal law, self-insured plans are exempt from state health insurance mandates.

In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA).[3] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA.

Lastly, the bill may result in a cost to the state pursuant to the ACA, to the extent the provisions of the bill are interpreted as an expansion of the current wheelchair benefit included in the state's benchmark plan.[4] The cost will depend on the utilization and cost of motorized wheelchairs for exchange plans. While states are allowed to mandate benefits in excess of the essential health benefits (EHB), federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. Absent further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan.

The Out Years

The fiscal impact described above will continue into the future based on whether or not the coverage requirements of the bill are

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[2] Source: https://health.costhelper.com/wheelchair.html

[3] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

[4] The state exchange's benchmark plan, the Connecticare Flex POS Plan provides coverage for wheelchairs pursuant to prior authorization. The plan document does not specify whether there is a distinction between manual and motorized wheelchairs. (Source: Connecticare HMO Open Access Member Agreement https://portal.ct.gov/-/media/CID/benchmarkplancontractpdf.pdf?la=en)

considered mandates pursuant to the ACA and the experience of exchange plan members. The impact to fully insured municipal plans will be reflected in plan premiums.