**Vermont Department of Banking, Insurance,
Securities & Health Care Administration**

**Division of Health Care Administration**

**Bulletin HCA-105**

# Actions of the 1999 Legislative Session Affecting Health Insurance and Coordination with Regulation H-99-1

**August 4, 1999**

During the 1999 session, the Vermont Legislature passed and the Governor signed two bills that affect medical health plan coverage in Vermont. Both apply to any individual or group health insurance policy, hospital or medical service corporation or health maintenance organization subscriber contract or any other health benefit plan offered, issued or renewed for any person in this state by a health insurer. However, these laws do not apply to benefit plans providing coverage for specific disease or other limited benefit coverage. The following describes the laws and compliance and coordination issues related to their implementation.

## H. 189: Reproductive Health Equity in Health Insurance Coverage

8 V.S.A.§4099c

### Coverage and Limitations

This law requires all health insurance plans to provide coverage for outpatient contraceptive services, including sterilizations, prescription contraceptives and prescription contraceptive devices approved by the federal Food and Drug Administration. However, a health insurance plan that does not provide coverage for prescription drugs is not required to provide coverage of prescription contraceptives and prescription contraceptive devices.

Health insurance plans providing this coverage may not establish any rate, term or condition that places a greater financial burden on an insured or beneficiary for these services than for access to treatment, prescriptions or devices for any other health condition.

### Effective Date

The Act took effect on July 1, 1999 and applies to all health benefit plans offered, issued or renewed on and after October 1, 1999 but in no event later than October 1, 2000.

## H. 351: An Act Relating to Health Insurance and Chiropractic Services

8 V.S.A.§4088a

**Coverage and Limitations**

The Act requires coverage of chiropractic services that are clinically (medically) necessary and provided by a licensed chiropractor within the legal scope of chiropractic practice, which is described in 10 V.S.A. § 521(3). However,

- the Act limits the coverage of adjunctive therapies to physiotherapy modalities and rehabilitative exercises; and
- health insurance plans do not have to provide coverage of chiropractic services for the treatment of any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs.
- Health insurance plans may impose the following requirements on the provision of chiropractic services coverage:
- A health insurer may require that the services be provided by a licensed chiropractic physician

    1. under contract with the insurer, or
    2. upon referral from a health care provider under contract with the insurer.

- Chiropractic services may be subject to reasonable deductibles, co-payment and co-insurance amounts, fee or benefit limits, practice parameters and utilization review consistent with applicable regulations. However, any such amounts, limits or review

    1. may not function to direct treatment in a manner unfairly discriminative against chiropractic care;
    2. collectively shall be no more restrictive than those applicable under the same policy to care or services provided by other health care providers; but
    3. may allow for the management of the chiropractic benefit consistent with variations in practice patterns and treatment modalities among different types of health care providers.

Health insurance plans may not unfairly discriminate against chiropractors in the way they design and implement this benefit. If an insurer applies utilization management strategies to chiropractic care that differ in kind from the utilization management strategies it applies to care provided by surgeons or internists, for example, the Department would not consider that in and of itself to be "unfairly discriminative." The Act permits health insurance plans to consider the differences in practice patterns among various types of providers (e.g., primary care physicians, specialists, physical therapists, etc.), and to manage the chiropractic benefit consistent with chiropractors' practice patterns. As long as an insurer does not unfairly restrict services or use utilization management methods to discriminate against a particular area of practice, matching the utilization management strategy to the nature of the practice pattern is permissible. If an

insurer uses a different utilization management strategy for chiropractic benefits, the insurer must include an explanation of the rationale for the chosen utilization management method in its form filing (see Filing Requirements).

**Effective Date**

The Act took effect on July 1, 1999 and applies to all health benefit plans offered, issued or renewed on and after October 1, 1999 but in no event later than October 1, 2000.

**Filing Requirements**

All future health filings must incorporate, where applicable, the services described in this Bulletin. The filing must contain all required information including appropriate language that clearly conveys the coverage to enrolled members. Such forms notifying enrolled members may be in the form of an endorsement to the contract or certificate, or may be contained in a new contract or certificate.

If the utilization management method applied to the chiropractic benefit differs from that applied to other covered health care services, the form filing concerning implementation of the Act Relating to Health Insurance and Chiropractic Services must include an explanation of the insurer's rationale for the chosen utilization management method for this benefit. For example, an insurer could identify a clinical profession it believes is similar in nature to chiropractic, and explain that it has applied to the chiropractic benefit the same utilization management method that it uses to manage health services provided by the similar profession; an insurer could explain that the utilization management method it applies to chiropractic is based on data from the literature or recognized clinical practice guidelines; an insurer could demonstrate that it is using existing and generally accepted chiropractic utilization management guidelines; or an insurer might have another explanation for its approach to utilization management of the chiropractic benefit.

If the utilization management method applied to the chiropractic benefit is the same as that applied to all other covered health care services, insurers need not include the above explanation/rationale with form filing submissions.

Filings must be received by this Department at least 30 days prior to their first intended use and cannot be used until approved by this Department. If the insurer's health insurance plans already comply with these laws, an informational filing will be sufficient. Filings must include a plan outlining the insurer's intended method of notification to all insureds of these new coverage mandates.

**Coordinating Implementation of New Mandates**

The effective dates of H.189, An Act Relating to Reproductive Health Equity in Health Insurance Coverage and H. 351, An Act Relating to Health Insurance and Chiropractic Services are identical. Regulation H-99-1, Independent External Review of Health Care Decisions, also took effect on July 1, 1999, but existing health insurance contracts or

forms with terms affected by that regulation may be used through June 30, 2000. For their own convenience, insurers are encouraged, but not required, to submit these changes in a single form filing with the Division and to coordinate required form changes. However, implementation of form changes required by Regulation H-99-1, Independent External Review of Health Care Decisions, may not be delayed beyond June 30, 2000.

Elizabeth R. Costle, Commissioner
Department of Banking, Insurance, Securities and Health Care Administration