

# MAINE STATE LEGISLATURE

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# Minority

L.D. 1236

Date: 2/3/14

(Filing No. S-376)

## INSURANCE AND FINANCIAL SERVICES

Reproduced and distributed under the direction of the Secretary of the Senate.

### STATE OF MAINE

### SENATE

### 126TH LEGISLATURE

### SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to S.P. 430, L.D. 1236, Bill, "An Act To Amend the Maine Insurance Code To Ensure Fair and Reasonable Coverage and Reimbursement of Chiropractic Services"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

**Sec. 1. 24-A MRS §2748**, as amended by PL 1993, c. 669, §2, is further amended to read:

**§2748. Coverage for chiropractic services**

**1. Therapeutic, adjustive and manipulative services.** Notwithstanding any other provisions of this chapter, every insurer ~~which that~~ issues health care contracts providing coverage for the services of a "physician" or "doctor" to residents of this State shall provide coverage and reasonable payment for medically necessary services to any subscriber or other person covered under those contracts for those services when performed by a ~~chiropractor~~ chiropractic doctor, to the extent that the services are within the lawful scope of practice of a ~~chiropractor~~ chiropractic doctor licensed to practice in this State. ~~Therapeutic~~ All therapeutic, adjustive and manipulative services shall must be covered and paid for in a reasonable and consistent manner whether performed by an allopathic, osteopathic or chiropractic doctor.

**2. Limits; coinsurance; deductibles.** Any contract ~~which that~~ provides coverage for the services required by this section may contain provisions for maximum benefits, reasonable copayment and coinsurance requirements and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section ~~or the limitations, coinsurance, deductibles or exclusions imposed on other providers~~ and do not exceed requirements imposed in conjunction with other provider services. Insurers may not classify services provided by chiropractic doctors as physical therapy or place these services into other categories that unreasonably limit coverage or payments for such services or increase copayment, coinsurance or deductible requirements imposed in conjunction with other provider services. The copayment for each service provided in the course of a chiropractic office visit may not

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1 exceed \$5 or 10% of the covered payment for such service, whichever is greater. The  
2 total copayment for the combined services provided in the course of a chiropractic office  
3 visit may not exceed \$30 or 10% of the combined covered payment for such services,  
4 whichever is greater.

5 **3. Reports to the Superintendent of Insurance.** Every insurer subject to this  
6 section shall report its experience for each calendar year to the Superintendent of  
7 Insurance not later than April 30th of the following year. The report must be in a form  
8 prescribed by the superintendent and include the amount of claims paid in this State for  
9 the services required by this section and the total amount of claims paid in this State for  
10 health care contracts. The report must include complaints concerning access to services  
11 under this section and the results of those complaints. The report must also provide data  
12 and analysis of the manner in which insurers are classifying and paying for chiropractic  
13 services, including the copayment, coinsurance and deductible requirements, in  
14 compliance with the requirements of this section. The superintendent shall compile this  
15 data for all insurers in an annual report.

16 **Sec. 2. 24-A MRSA §2840-A, sub-§§1 and 2,** as enacted by PL 1985, c. 516,  
17 §5, are amended to read:

18 **1. Therapeutic, adjustive and manipulative services.** Notwithstanding any other  
19 provisions of this chapter, every insurer ~~which~~ that issues group or blanket health care  
20 contracts providing coverage for the services of a "physician" or "doctor" to residents of  
21 this State shall provide coverage and reasonable payment for medically necessary  
22 services to any subscriber or other person covered under those contracts for those services  
23 when performed by a ~~chiropractor~~ chiropractic doctor, to the extent that the services are  
24 within the lawful scope of practice of a ~~chiropractor~~ chiropractic doctor licensed to  
25 practice in this State. ~~Therapeutic~~ All therapeutic, adjustive and manipulative services  
26 shall must be covered and paid for in a reasonable and consistent manner whether  
27 performed by an allopathic, osteopathic or chiropractic doctor.

28 **2. Limits; coinsurance; deductibles.** Any contract ~~which~~ that provides coverage  
29 for the services required by this section may contain provisions for maximum benefits  
30 and, reasonable copayment and coinsurance requirements and reasonable ~~limitations,~~  
31 deductibles and exclusions to the extent that these provisions are not inconsistent with the  
32 requirements of this section and do not exceed requirements imposed in conjunction with  
33 other provider services. Insurers may not classify services provided by chiropractic  
34 doctors as physical therapy or place these services into other categories that unreasonably  
35 limit coverage or payments for such services or increase copayment, coinsurance or  
36 deductible requirements imposed in conjunction with other provider services. The  
37 copayment for each service provided in the course of a chiropractic office visit may not  
38 exceed \$5 or 10% of the covered payment for such service, whichever is greater. The  
39 total copayment for the combined services provided in the course of a chiropractic office  
40 visit may not exceed \$30 or 10% of the combined covered payment for such services,  
41 whichever is greater.

42 **Sec. 3. 24-A MRSA §2840-A, sub-§3,** as amended by PL 1993, c. 669, §3, is  
43 further amended to read:

44 **3. Reports to the Superintendent of Insurance.** Every insurer subject to this  
45 section shall report its experience for each calendar year to the Superintendent of

# COMMITTEE AMENDMENT

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1 Insurance not later than April 30th of the following year. The report must be in a form  
2 prescribed by the superintendent and include the amount of claims paid in this State for  
3 the services required by this section and the total amount of claims paid in this State for  
4 health care contracts. The report must include complaints concerning access to services  
5 under this section and the results of those complaints. The report must also provide data  
6 and analysis of the manner in which insurers are classifying and paying for chiropractic  
7 services, including the copayment, coinsurance and deductible requirements, in  
8 compliance with the requirements of this section. The superintendent shall compile this  
9 data for all insurers in an annual report.

10 **Sec. 4. 24-A MRSA §4236**, as amended by PL 1997, c. 99, §1, is further amended  
11 to read:

12 **§4236. Chiropractic doctors in health maintenance organizations**

13 Every health maintenance organization shall include in every plan for health care  
14 services chiropractic services delivered by qualified chiropractic ~~providers~~ doctors in  
15 accordance with this section.

16 **1. Qualifications of chiropractic doctors.** The health maintenance organization  
17 shall determine the qualifications of chiropractic ~~providers~~ doctors using reasonable  
18 standards that are similar to and consistent with the standards applied to other providers.

19 **2. Benefits.** The health maintenance organization shall provide benefits covering  
20 and paying for care by chiropractic ~~providers~~ doctors at least equal to and consistent with  
21 the benefits paid to other health care providers treating similar neuro-musculoskeletal  
22 conditions within the scope of practice of chiropractic doctors. The health maintenance  
23 organization may not classify services provided by chiropractic doctors as physical  
24 therapy or place these services into other categories that unreasonably limit coverage or  
25 payments for such services or impose copayment, coinsurance or deductible requirements  
26 that exceed those imposed with respect to services of other providers. The copayment for  
27 each service provided in the course of a chiropractic office visit may not exceed \$5 or  
28 10% of the covered payment for such service, whichever is greater. The total copayment  
29 for the combined services provided in the course of a chiropractic office visit may not  
30 exceed \$30 or 10% of the combined covered payment for such services, whichever is  
31 greater.

32 **3. Self-referrals for chiropractic care.** A health maintenance organization must  
33 provide benefits to an enrollee who utilizes the services of a chiropractic ~~provider~~ doctor  
34 by self-referral under the following conditions.

35 A. An enrollee may utilize the services of a participating chiropractic ~~provider~~ doctor  
36 within the enrollee's health maintenance organization for 3 weeks or a maximum of  
37 12 visits, whichever occurs first, of acute care treatment without the prior approval of  
38 a primary care provider of the health maintenance organization. For purposes of this  
39 subsection, "acute care treatment" means treatment for accidental bodily injury or  
40 sudden, severe pain that affects the ability of the enrollee to engage in the normal  
41 activities, duties or responsibilities of daily living.

42 B. Within 3 working days of the first consultation, the participating chiropractic  
43 ~~provider~~ doctor shall send to the primary care provider a report containing the

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1 enrollee's complaint, related history, examination, initial diagnosis and treatment  
2 plan. If the chiropractic ~~provider~~ doctor fails to send a report to the primary care  
3 provider within 3 working days, the health maintenance organization is not obligated  
4 to provide benefits for chiropractic care and the enrollee is not liable to the  
5 chiropractic ~~provider~~ doctor for any unpaid fees.

6 C. If the enrollee and the participating chiropractic ~~provider~~ doctor determine that  
7 the condition of the enrollee has not improved after 3 weeks of treatment or a  
8 maximum of 12 visits, the participating chiropractic ~~provider~~ doctor shall discontinue  
9 treatment and refer the enrollee to the primary care provider.

10 D. If the chiropractic ~~provider~~ doctor recommends treatment beyond 3 weeks or a  
11 maximum of 12 visits, the participating chiropractic ~~provider~~ doctor shall send to the  
12 primary care provider a report containing information on the enrollee's progress and  
13 outlining a treatment plan for extended chiropractic care of up to 5 more weeks or a  
14 maximum of 12 more visits, whichever occurs first.

15 E. Without the approval of the primary care provider, an enrollee may not receive  
16 benefits for more than 36 visits to a participating chiropractic ~~provider~~ doctor in a  
17 12-month period. After a maximum of 36 visits, an enrollee's continuing chiropractic  
18 treatment must be authorized by the primary care provider.

19 In the provision of chiropractic services under this subsection, a participating chiropractic  
20 ~~provider~~ doctor is liable for a professional diagnosis of a mental or physical condition that  
21 has resulted or may result in the chiropractic ~~provider~~ doctor performing duties in a  
22 manner that endangers the health or safety of an enrollee.

23 The provisions of this subsection apply to all health maintenance organization contracts,  
24 except a contract between a health maintenance organization and the State Employee  
25 Health Insurance Program.

26 This subsection takes effect January 1, 1996.

27 **Sec. 5. Application.** The requirements of this Act apply to all policies, contracts  
28 and certificates executed, delivered, issued for delivery, continued or renewed in this  
29 State on or after January 1, 2015. For the purposes of this Act, all contracts are deemed  
30 to be renewed no later than the next yearly anniversary of the contract date.'

31 **SUMMARY**

32 This amendment is the minority report of the committee and replaces the bill. The  
33 amendment requires coverage and reasonable payment by health insurers and health  
34 maintenance organizations for medically necessary services within the scope of practice  
35 of chiropractic doctors. It requires insurers to provide benefits covering and paying for  
36 care by chiropractic doctors. Under the amendment, these carriers may not classify  
37 services provided by chiropractic doctors as physical therapy or place these services into  
38 other categories that unreasonably limit coverage or payments for such services. It also  
39 prohibits the imposition of unreasonable patient copayment, coinsurance or deductible  
40 requirements that exceed those patient obligations imposed with respect to other provider  
41 services. The copayment for each service provided in the course of an office visit to a  
42 chiropractic doctor may not exceed \$5 or 10% of the covered payment for such service,

**COMMITTEE AMENDMENT**



COMMITTEE AMENDMENT "A" to S.P. 430, L.D. 1236

1 whichever is greater. The total copayment for the combined services provided in the  
2 course of an office visit to a chiropractic doctor may not exceed \$30 or 10% of the  
3 combined covered payment for such services, whichever is greater.

4 **FISCAL NOTE REQUIRED**

5 (See attached)

**COMMITTEE AMENDMENT**



# 126th MAINE LEGISLATURE

LD 1236

LR 1885(02)

**An Act To Amend the Maine Insurance Code To Ensure Fair and Reasonable Coverage and Reimbursement of Chiropractic Services**

**Fiscal Note for Bill as Amended by Committee Amendment "A" (S-376)**

**Committee: Insurance and Financial Services**

**Fiscal Note Required: Yes**

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## Fiscal Note

Minor cost increase - General Fund

Minor cost increase - Other Special Revenue Funds

### Fiscal Detail and Notes

Any additional costs to the State Employee Health Insurance Program are expected to be minor and can be absorbed within existing budgeted resources. Additional costs to the Bureau of Insurance in the Department of Professional and Financial Regulation are expected to be minor and can be absorbed within existing budgeted resources.