488 Washington Avenue
West Haven, CT 06516

August 1, 2016

Connecticut Insurance Department

7th Floor, 153 Market Street

Hartford, CT

To Whom It May Concern:

I am writing in response to an article in the New Haven Register regarding the proposed insurance rate hikes by the companies serving Connecticut. I am currently covered by ConnectiCare which increased the premiums for my plan by $30.00 a month for the current year. The premium was $60.00 per month for the previous year. I find it troubling that they now wish to increase the premiums by an average of 14.3 percent. Their justification for the increase is the anticipated 10.5 percent increase in medical costs and the expiration of the federal government's transitional reinsurance program, a fact that was known to all of the insurance providers in the state at the time that the Affordable Care Act became law.

I understand that the Connecticut Insurance Department 's job is limited to making sure that the premiums cover the claims and does not discriminate against any specific group of clients. Consumer affordability will not be considered as part of the review process. Why not? Increased rates may force some people to drop their insurance and once again return to using emergency room care instead of a private physician or a clinic. Insurance companies should not be allowed to

Testimony

Anne Watkins

25 Avon Street, New Haven, CT 06511

Re: ConnectiCare Rate Increase Request

Good morning. My name is Anne Watkins. I am a member of CONECt, resident of New Haven, parent and a small business owner – an organizational and leadership development consultant, in fact.

When we were changing insurance plans a couple of years ago we noticed that rates are startlingly lower in states like Minnesota.

Instead of embarking on a move we decided upon ConnectiCare as our insurer. For the priviledge, we pay more than $11,000 annually- more than $900 per month for a family of four. We have a $10,000 family deductible.

As a small business owner, this inhibits the growth of my business.

ConnectiCare is proposing a rate in increase of 29.8% or in my case $3,000 annually. At this point I fee a bit like a pawn in these health care executives game of chess. They propose a ridiculous increase, we come and speak before you and we all acknowledge that the proposed increase is too high. So, perhaps it increases only 10% or $1,000 annually for my family.

As a leadership development consultant, I sometimes remind folks of some research done in 2007 regarding executives and cookies. In this research, when executives and lower level staff were presented with a plate of cookies with only one extra, the executive almost always took the extra cookie.

The system we have is broken. Insurance executives are lining their pockets at the expense of regular people trying to make their way in Connecticut.

According to Bloomberg News, Michael Wise, CEO of ConnectiCare makes $1.1 million annually in salary and bonuses, with 10.8 million in options.

Hands off that plate of cookies, Mr. Wise.

Perhaps we should rethink that move to Minnesota afterall.

CONECT

Congregations Organized for a New Connecticut

Congregaciones Organizadas para un Nuevo Connecticut

TESTIMONY OF CONECT

RE: CONNECTICARE RATE INCREASE REQUEST FOR 2017

Good morning. My name is Dr. Elizabeth Keenan and I am co-chair of the Healthcare Team for CONECT, (Congregations Organized for a New Connecticut), a multi-faith, multi-issue, non-partisan organization representing 15,000 people from 28 religious congregations and civic organizations in Fairfield and New Haven counties.

We are here to comment on ConnectiCare's request for an average 24.30 percent increase on its individual off-exchange plans for 2017. These plans cover a total of 37,142 lives. Not affected will be persons with ConnectiCare's Medicare Advantage plans or persons covered through its on-exchange plans or by its employer-sponsored plans, although all these people are likely to see increases in their health insurance costs as well.

As we noted in our testimony yesterday on Anthem Health Plans' 2017 rate increase request, the Connecticut Insurance Department is required by state statute to evaluate any proposed rate increase based on whether, from an actuarial perspective, it is "excessive, inadequate or unfairly discriminatory." We note that state statute is silent on the issue of affordability.

In our minds, that means the Department is free to take into account whether any proposed rate increase can be justified in terms of its affordability. To us, affordability can be defined as any increase that is equal to or less than the projected increases in health care costs for the year in question, as determined by the Office of the Actuary, Center for Medicare and Medicaid Services.

ConnectiCare, in its filing, claims that a significant factor affecting its 2017 rate request was the discontinuation of the federal government's transition reinsurance program for the individual market. Under this program, started with the inception of the Affordable Care or ACA in 2014, insurers were provided with funds to offset what was expected to be higher claims costs from newly insured persons, that is, persons who, prior to the introduction of the ACA, had no health insurance and who now were expected to need more medical services.

This program was always meant to be a temporary measure, not a permanent feature of the ACA. Insurers knew this from the beginning, and for them now to raise the ending of this program to justify in part their rate requests increases for 2017 is nothing more than opportunism at its worst. We urge the Department to reject this argument in its final ruling.

We also note that while insurers in other states have also announced proposed rate increases for 2017, most of these average in the mid-to-low double digits Only a few have announced increases the size of ConnectiCare's.

There is also a great deal of incomplete, missing or inconsistent actuarial data in the ConnectiCare application, data that are essential if the Department is to carry out a thorough analysis of the request.

Much of these missing data elements have been cited by the Department in its 12 follow-up questions to the insurer. They include information on claims experience, morbidity deterioration, and per-member-per-month cost for certain services and for direct and broker administrative services.

The Department also asked for additional data to explain and support the various rates by plan being sought by the insurer. These rate changes range from 16 percent to what we consider to be an unreasonable 44.4 percent. We support the Department in its effort to obtain this critical information.

Such incomplete documentation not only undermines ConnectiCare's underlying assumptions with respect to the rates it is seeking, it also makes it extremely difficult to assess the reasonability of the insurer's request.

Finally, it should be noted that ConnectiCare filed its request prior to the announcement by a competitor – HealthyCT – that it was withdrawing from the market. Given this development, however, we believe ConnectiCare should now be required to provide data and analysis on what the likely impact of this action will be on its proposed rates for 2017.

This is particularly essential because Healthy CT's demise was the result of a $13 million ACA risk pool payment (owed because their insureds were deemed to be healthier and less costly that those of other carriers). Now, as these people become the customers of ConnectiCare, and other insurers in 2017 (40,000 of them!), it would seem logical to conclude their experience would help bring rates down.

In conclusion, we believe that, until some of these data gaps and other information, including impact on affordability, are addressed in a revised filing, ConnectiCare's request should not be approved. Thank you.

This program was always meant to be a temporary measure, not a permanent feature of the ACA. Insurers knew this from the beginning, and for them now to raise the ending of this program to justify in part their rate requests increases for 2017 is nothing more than opportunism at its worst. We urge the Department to reject this argument in its final ruling.

We also note that while insurers in other states have also announced proposed rate increases for 2017, most of these average in the mid-to-low double digits Only a few have announced increases the size of ConnectiCare's.

There is also a great deal of incomplete, missing or inconsistent actuarial data in the ConnectiCare application, data that are essential if the Department is to carry out a thorough analysis of the request.

Much of these missing data elements have been cited by the Department in its 12 follow-up questions to the insurer. They include information on claims experience, morbidity deterioration, and per-member-per-month cost for certain services and for direct and broker administrative services.

The Department also asked for additional data to explain and support the various rates by plan being sought by the insurer. These rate changes range from 16 percent to what we consider to be an unreasonable 44.4 percent. We support the Department in its effort to obtain this critical information.

Such incomplete documentation not only undermines ConnectiCare's underlying assumptions with respect to the rates it is seeking, it also makes it extremely difficult to assess the reasonability of the insurer's request.

Finally, it should be noted that ConnectiCare filed its request prior to the announcement by a competitor – HealthyCT – that it was withdrawing from the market. Given this development, however, we believe ConnectiCare should now be required to provide data and analysis on what the likely impact of this action will be on its proposed rates for 2017.

This is particularly essential because Healthy CT's demise was the result of a $13 million ACA risk pool payment (owed because their insureds were deemed to be healthier and less costly that those of other carriers). Now, as these people become the customers of ConnectiCare, and other insurers in 2017 (40,000 of them!), it would seem logical to conclude their experience would help bring rates down.

In conclusion, we believe that, until some of these data gaps and other information, including impact on affordability, are addressed in a revised filing, ConnectiCare's request should not be approved. Thank you.

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

Commissioner Katharine L. Wade
Connecticut Department of Insurance
153 Market Street
Hartford, CT 06103

August 4, 2016

Re: Health Insurance Rate Increase

Commissioner Wade,

On behalf of the Connecticut Chiropractic Association and chiropractic physicians throughout the state I am addressing proposed insurance rate increases for Anthem Health Plans, Aetna Life Insurance Company and ConnectiCare Insurance Company, and to share our concerns about policies established by these companies that reduce the full scope of chiropractic practice as allowed by law thus compromising patient rights to select their chiropractic physician for their general, primary and specialty health care needs. We submitted a letter addressing our concerns yesterday.

Aetna and Connecticare have stated they are in compliance with the Patient Protection and Affordable Care Act (PPACA) for Exchange and Non-Exchange Plans in their Executive Summaries. We disagree. The Patient Protection and Affordable Care Act - section 2706, specifically prohibits health care provider discrimination. Connecticut statute section 38a-591 specifically requires all plans sold on the Exchange follow PPACA - section 2706 and also the state's mandates. In the state's mandates for individual and group health plans, Section 38-507 and section 38-534 specifically require insurers to cover chiropractic services to the same extent as coverage is provided for medical services.

In our experiences and upon review of insurance plan policies sold on and off the Exchange, we find health insurance plans to be in violation of Section 2706 of the PPACA and in violation with Sections 38-507 and 38-534 of Connecticut statutes in the following ways:

- No company presents chiropractic physicians to subscribers and potential patients to the same extent as medical doctors are presented. This steers patients into medical practices and improperly restrains the fair trade of the healing arts.
- All plans impose limits to chiropractic physical treatments when no such limits are imposed upon medical physical treatments. This increases the costs burden of patients. This is especially noteworthy for the Connecticut 2017 Essential Health Benefits Benchmark Plan which is patterned after the ConnectiCare Flex POS plan.
- Most if not all plans ascribe chiropractic physicians as specialists that cause higher co-payments imposed upon patients. A more reasonable, realistic and traditional role to ascribe the chiropractic physician is as a primary care physician or generalist. This categorization is associated with a much lower co-payment for examination and consultation services.
- One company offers a reimbursement policy to chiropractic physician's that is non-congruent with reimbursement policy offered to medical doctors. The policy offered to chiropractic physicians limits payment of services to a per diem rate. Thus, a time limit is imposed upon the chiropractic physician. The reimbursement policy offered to a medical doctor is based upon each service provided. There is no time limit imposed upon medical doctors. Thus, the MD is reimbursed for each service provided. Each service is coded to account for the service level of skill and time to deliver the service. Thus, the coverage for chiropractic services cannot be covered to the same extent as coverage is provided for medical services. Patients are harmed by this policy.

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

There is ample data to demonstrate chiropractic services do not increase costs to consumers, insurers and the health care system in general. In fact a study where the full scope of chiropractic care was utilized in Blue Cross Blue Shield of Illinois policies where patients utilized their chiropractors as their Primary Care Physician demonstrated the following results:

- 60% decrease in in-hospital admissions
- 59% decrease in hospital days
- 62% decrease in outpatient surgeries and procedures
- 85% decrease in pharmaceutical costs

With results like these you would expect all insurance companies, especially Anthem Blue Cross Blue Shield, to proactively recruit more chiropractic physicians into their plans with policies and a reimbursement schedule that allows the doctor to provide their full scope of practice and also promote the full scope of chiropractic services to their subscribers and hospitals. This is not so. It is just the opposite where their policies limit exposure to chiropractic care and they offer reimbursement schedules that prohibit the delivery of the full scope of chiropractic practice thus forcing patients into pharmaceutical approach of health care and higher costs. One has to wonder insurance company motives for raising premiums if they ignore proven methods of delivering health care more cost-effectively.

It is therefore our position that no insurance rates be raised until the insurance companies change their policies to be in compliance with federal and state laws. Such legal compliance is within the purview of the Department of Insurance. We believe other government regulators should be involved including the Attorney General's office, Office of Health Care Access, Comptroller's office, Department of Public Health and Access Health Connecticut. We believe the Department of Insurance must rely upon the opinions and approval from organizations representing the medical, chiropractic, naturopathic, podiatric, optometry, behavioral health and advanced practice registered nursing professions to authorize compliance of state and federal laws.

We have attached documents supporting our statements. We are always available to discuss these issues further and look forward to working the Department of Insurance, insurance companies, government regulators, legislators and patient advocacy organizations to assure patient liberties in the health care system are protected and all providers can practice to the full extent of their license.

Thank you,

Richard Duenas, D.C.
President
Connecticut Chiropractic Association

Attachments
Copy: file

CTChiro

Connecticut Chiropractic Association

ctchiro.com

Research Regarding the Cost-Effectiveness and Clinical Outcomes of Chiropractic Care

Summary of Findings

- A patient receiving regular chiropractic care experiences reduced hospital admissions, surgeries, and pharmaceutical costs.
- Studies indicate that greater chiropractic coverage, despite increased visits to a DC, results in significant net savings in both indirect and direct costs.
- Chiropractic care could reduce Medicare costs--both payment for all services and average per claim payment.
- Chiropractic students are better prepared to address musculoskeletal issues than medical students and most doctors.
- Chiropractic patients typically pay less and are more satisfied with their treatment than MD patients.
- Chiropractic care can be used to control health care costs.
- Chiropractic patients reach maximum medical improvement sooner than when treated by a medical doctor.

"My research, conducted over a ten-year period utilizing clinical and cost outcomes data from one of the nations largest insurance underwriters, suggests that the regular utilization of chiropractic could reduce the need for hospitalization, pharmaceutical usage and overall global health care costs by almost 50 percent."

- Richard I. Sarnat, M.D., President of Alternative Medicine Integration (AMI)

Examine the Research for Yourself

1. The Alternative Medicine Integration Study. Journal of Manipulative and Physiological Therapeutics, May 2007. Study results available at: www.jmptonline.org/article/S0161-4754(07)00076-0/abstract.

- The Alternative Medicine Integration Study was updated in 2007, covering the years of 2003-05. Results of the original study were confirmed.
- Chiropractic care patients demonstrated:
  - 60% decrease in in-hospital admissions
  - 59% decrease in hospital days
  - 62% decrease in outpatient surgeries and procedures
  - **85% decrease in pharmaceutical costs**

---

2. Clinical and Cost Outcomes of an Integrative Medicine IPA. Sarnat, Richard; Winterstein, James. Journal of Manipulative and Physiological Therapeutics 2004; 27: 336-347.

- In 1999, a large Chicago HMO began to utilize doctors of chiropractic (DCs) in a primary care provider role.
- During the 4-year study, this integrative medical approach, emphasizing a variety of complimentary and alternative medical (CAM) therapies, resulted in lower patient costs and improved clinical outcomes for patients.
- The patients who went to DCs as their primary care providers had:
  - 43% decrease in hospital admissions
  - 52% reductions in pharmaceutical costs
  - **43% fewer outpatient surgeries and procedures**

---

3. Enhanced Chiropractic Coverage Under OHIP (Ontario Health Insurance Plan) as a Means for Reducing Health Care Costs, Attaining Better Health Outcomes, and Achieving Equitable Access To Health Services. Manga, Pran. Report to the Ontario Ministry of Health, 1998.

- Demonstrates deterrence of the use of chiropractic care because it is not covered under OHIP.
- Authors indicate that greater chiropractic coverage under OHIP would result in a greater number of individuals visiting chiropractors and more frequent visits.
- Study shows that, despite increased visits to DCs, a net savings in both direct and indirect costs would be experienced. **Direct savings for Ontario's health care system would range between $380-770 million.**

---

4. Utilization, Cost, and Effects Of Chiropractic Care On Medicare Program Costs. Muse and Associates. American Chiropractic Association 2001.

- Examines cost, utilization, and effects of chiropractic services on Medicare costs.
- Compares program payments and service utilization for Medicare beneficiaries who visited DCs and those who visited other types of physicians.
- Results indicate that chiropractic care could reduce Medicare costs.
- **Average Medicare payment (all services) for beneficiaries who had chiropractic care: $4,426.** Average Medicare payment (all services) for beneficiaries who had other types of care: $8,102.
- The per claim average payment was also lower: $133 vs. $210.

---

5. Cost of Care for Common Back Pain Conditions Initiated with Chiropractic Doctor vs. Medical Doctor/Doctor of Osteopathy as First Physician: Experience of One Tennessee-Based General Health Insurer. Richard L. Liliendahl, M.D.; Michael D. Finch,

1.D.; David Axnene, FSA; Christine M. Goertz, EC, Ph.D. Journal of Manipulative and Physiological Therapeutics. Vol. 33, Issue 9.

Paid cost for episodes of care initiated with a DC were almost 40% less than episodes initiated with an MD.
Even after risk adjusting each patient's cost, episodes of care initiated with a DC were 20% less expensive than those initiated with an MD.

An Examination of Musculoskeletal Cognitive Competency in Chiropractic Interns. Humphreys, B.K.; Sulkowski, A.; Mc Intyre, K.; Kasiban, M.; Patrick, A.N. Journal of Manipulative Physiological Therapeutics 2007 Jan; 30(1):44-9.

Prior studies have concluded that musculoskeletal medical education is inadequate; yet, musculoskeletal complaints are one of the most common reasons for seeking physician care.
This study compared the results of 154 fourth-year chiropractic interns that completed the Basic Competency Examination in musculoskeletal medicine.
Most interns passed the test with results that were considerably better than those of recent medical graduates and physical therapy doctorate students. The chiropractic intern scores were also higher than those of orthopedic staff physicians.
The 51%-64% success rate of chiropractors was almost double the 20%-30% rate of medical students and doctors.

Costs and Recurrences of Chiropractic and Medical Episodes of Low Back Care. Smith, M.; Stano, M. Journal of Manipulative and Physiological Therapeutics 1997; 20(1): 5-12.

Compares the health insurance payments and patient utilization patterns of individuals suffering from recurring low back pain who visited DCs or MDs.
Insurance payments were higher for medically initiated episodes.
Those who visited chiropractors paid less and were more satisfied with the care given.
The study suggests that chiropractic care should be given careful attention by employers when using gate-keeper strategies.

Chiropractic and Medical Costs of Low Back Care. Stano, M., Smith, M. Medical Care 1996; 34(3): 191-204.

Compares health insurance payments and patient utilization patterns for episodes of care for common lumbar and low back conditions treated by chiropractic and medical providers (uses 2 years of insurance claims data and examines more than 6,000 patients who had episodes with medical or chiropractic first-contact providers).
Total insurance payments were substantially greater for episodes with a medical first-contact provider. **(Mean total payment was $1,020 with an MD vs. $518 with a DC.)**

9. Stano, Miron. The Economic Role of Chiropractic Further Analysis of Relative Insurance Costs for Low Back Care. Journal of the Neuromusculoskeletal System 1995; 3(3): 139-144.

- This retrospective study of 7,000+ patients compared costs of care for common low back conditions when a DC was used versus an MD as the first provider.
- Payments for inpatient procedures were higher for MD-initiated treatment, especially for episodes that lasted longer than one day.
- Outpatient payments were nearly 50% higher for MD-initiated treatments as well.
- **The author concluded that chiropractic care could help to control health care spending.**

10. Lost Productive Time and Cost Due to Common Pain Conditions in the U.S. Workforce. Stewart, W.F., Ricci, J.A., Chee, E., Morganstein, D.; Lipton, R. Journal of the American Medical Association 2003. Nov 12; 290(18): 2443-54.

- Researchers questioned 29,000 respondents regarding the cost implications of reduced performance due to headaches, arthriti back pain, and other musculoskeletal pain.
- Participants also responded as to whether common pain conditions had caused them to lose concentration, repeat jobs, do nothing, or feel fatigued at work.
- **The cost of lost productive time in the U.S. workforce was found to be $61 billion, and 76% of that cost was attributed to health-related reduced performance.**
- Data revealed that 1.1% of the workforce were absent one or more days per week because of common pain conditions.

---

11. Comparative Analysis of Individuals With and Without Chiropractic Coverage. Legorreta, A.; Metz, D.; Nelson, C.; Ray, S.; Chernicoff, H.; DiNubile, N. Archives of Internal Medicine 2004; 164: 1985-1992.

- A 4-year retrospective review of claims from 1.7 million health plan members were analyzed to determine the cost effects of the inclusion of a chiropractic benefit in an HMO insurance plan.
- Members with a chiropractic benefit had lower overall total annual health care costs.
- Back pain patients with chiropractic coverage also realized lower utilization of plain radiographs, low back surgery, hospitalizations and MRIs.
- **Back pain episode-related costs were 25% lower for those with chiropractic coverage ($289 vs. $399).**

---

12. Cost Comparisons of Chiropractic Care Versus Other Health Care Provider. Texas Workers' Compensation Report.[1]

"The average cost of [low back injury] claims is $15,884. **When a worker with a lower back injury receives at least 75% of his/her care from a chiropractor, that cost decreases to $12,202** and **when he/she receives at least 90% of their care from a chiropractor the average cost declines even further to $7,632.**"

[1] MGT of America, Inc. Chiropractic Treatment of Workers' Compensation Claimants in the State of Texas (Austin, Texas: 2003).

---

13. Chiropractic Care of Florida Workers' Compensation Claimants: Access, Costs, and Administrative Outcome Trends from 19 to 1999. Folsom, B.L.; Holloway, R.W. Topics in Clinical Chiropractic 2002; 9(4): 33-53.

- Study revealed that average total cost for low-back cases treated medically was $16,998, while chiropractic care was only $7,30
- Patients treated primarily by chiropractors were found to **reach maximum medical improvement almost 28 days sooner** than i treated by a medical doctor.
- Considerable cost savings and more efficient claims resolution may be possible with greater involvement of chiropractic treatment in specific low back cases and other specific musculoskeletal cases.

---

14. FYI-IPA. Gemmell, H.A., Hayes, B.M. Patient Satisfaction with Chiropractic Physicians in an Independent Physicians Associa tion. Journal of Manipulative and Physiological Therapeutics 2001; 24(9): 556-559.

- In this study, 150 chiropractic patients were surveyed.
- Chiropractic care received excellent remarks by percentage, in the following categories:
  - Time to get an appointment – 85%
  - Convenience of office - 58%
  - Access to office by phone - 77%
  - Length of wait - 76%
  - Time spent with provider - 74%
  - Explanation of treatment - 73%
  - Skill of provider - 83%
  - Personal manner of the chiropractor - 92%
  - Overall visit - 83%

CT chiro
Connecticut Chiropractic Association
www.ctchiro.com
2257 Silas Deane Highway | Rocky Hill, CT 06067
(860) 257-0404 | 1-800-966-BACK
www.ctchiro.com

CTchiro
Connecticut Chiropractic Association
www.ctchiro.com

Research Regarding the Cost-Effectiveness and Clinical Outcomes of Chiropractic Care

Summary of Findings

Tracking low back problems ...

The chiropractic group had:

- lowest prescription medication rates
- least costs per episode of low back pain
- least guideline-incongruent use of medications and imaging
- least likelihood to receive complex medical procedures like surgeries

$6,983.82
Chiropractic Management

vs.

$28,231.50
Complex Medical Management

4

- **Patients receiving chiropractic care have the lowest prescription medication rates, least costs per episode of low back pain, and least guideline-incongruent use of medications and imaging**
- **Chiropractic can provide greater reductions in self-reported disability and pain compared with usual medical care for acute and subacute low back pain**
- **Overall satisfaction among persons using chiropractic is very high**
- **Studies find that chiropractic is effective in the management of neck and back pain**
- **Spinal manipulation is a cost-effective treatment to manage spinal pain**
- **Including chiropractic care with standard obstetric care benefits patients**
- **Seniors have lowered risk of injury following chiropractic visit than medical visit**
- **Injured workers whose first visit was to a chiropractor had significantly lower odds of surgery**

Chiropractic Efficacy Literature Review, Don't just take our word for it! Examine the Research for Yourself ...

1 **Spinal manipulation epidemiology: systematic review of cost effectiveness studies.**
Michaleff ZA, Lin CW, Maher CG, van Tulder MW. J Electromyogr Kinesiol. 2012;22(5):655-62.

Summary: Spinal manipulation is a cost-effective treatment to manage spinal pain

- Spinal manipulation is a **cost-effective treatment to manage neck and back pain** when used alone or in combination with other techniques compared to GP (general practitioner) care, exercise and physiotherapy

2 Comparison of spinal manipulation methods and usual medical care for acute and subacute low back pain: a randomized clinical trial.

Schneider M, Haas M, Glick R, Stevans J, Landsittel D. Spine (Phila Pa 1976). 2015;40(4):209-17.

Summary: Chiropractic manipulation effective in short term treatment of acute and subacute low back pain

- Chiropractic manual manipulation can **provide greater reductions in self-reported disability and pain compared with usual medical care** for acute and subacute low back pain
- Manual manipulation by a chiropractor should be considered as an effective short term treatment option for patients with acute and subacute low back pain
- Significantly more patients in the manual manipulation group achieved moderate or substantial reductions in disability and pain scores compared to usual medical care

3 Changes in H-reflex and V-waves following spinal manipulation.

Niazi IK, Turker KS, Flavel S, Kinget M, Duehr J, Haavik H. Exp Brain Res. 2015;233(4):1165-73.

Summary: Chiropractic prevents fatigue and increases muscle strength

- Chiropractic adjustments **prevent fatigue and increase muscle strength**
- These results suggest that chiropractic adjustments may be indicated as part of the treatment for the patients who have lost tone of their muscle and/or are recovering from muscle dysfunction such as stroke or orthopedic operations
- These findings will also be of interest to athletes and perhaps the general public

Risk of traumatic injury associated with chiropractic spinal manipulation in Medicare Part B beneficiaries aged 66 to 99 years.

Injury in the chiropractic group was **40** injury incidents per 100,000 subjects

vs.

153 incidents per 100,000 subjects in the primary care group

12

4 Tracking low back problems in a major self-insured workforce: toward improvement in the patient's journey.

Allen H, Wright M, Craig T, Mardekian J, Cheung R, Sanchez R, et al. J Occup Environ Med. 2014;56(6):604-20.

Summary: Lower costs and less drug use in the workplace with chiropractic

The goal of this study was to assess the cost outcomes of treatment approaches to care for back problems in a major self-insured workforce, using published guidelines to focus on low back pain. Three types of care were followed (complex medical management, chiropractic care, physical therapist care).

- The chiropractic group had **the lowest prescription medication rates, least costs per episode of low back pain, and least guideline-incongruent use of medications and imaging**
- The chiropractic group also was the least likely to receive complex medical procedures like surgeries
- **Complex medical management costs were greater than 4 times more expensive** for an episode of low back pain (over 3 years) with neurological findings than chiropractic care ($6,983.82 vs $28,231.5)
- Physical therapy **costs were more than double** per episode of low back pain (over 3 years) with neurological findings compared with chiropractic care ($6,983.82 vs $17,193.92)
- Similar cost savings in favor of chiropractic were found for an episode of low back pain (over 3 years) without neurological findings (chiropractic care = $6,768.43, complex medical management = $29,344.25, physical therapy = $13,448.82)

5 Evidence-based guidelines for the chiropractic treatment of adults with neck pain.

Bryans R, Decina P, Descarreaux M, Duranleau M, Marcoux H, Potter B, Ruegg RP, Shaw L, Watkin R, White E. J Manipulative Physiol Ther. 2014 Jan;37(1):42-63.

Summary: Neck manipulation is recommended in the chiropractic treatment of neck pain

- Studies indicate that **neck manipulation (adjustment), mobilization, manual therapy, exercise, and massage can be recommended** for the chiropractic treatment of nonspecific, mechanical neck pain
- The strongest recommendations are usually made for neck manipulation in combination with another intervention (usually exercise and/or patient education)

6 Patient education with or without manual therapy compared to a control group in patients with osteoarthritis of the hip.

Poulsen E, Hartvigsen J, Christensen HW, Roos EM, Vach W, Overgaard S. A proof-of-principle three-arm parallel group randomized clinical trial. Osteoarthritis Cartilage. 2013 Oct;21(10):1494-503.

Summary: Chiropractic can aid patients with hip osteoarthritis

- For primary care patients with osteoarthritis of the hip, combined treatment of manual therapy provided by a chiropractor and patient education was **more effective than a minimal control intervention**
- Clinical improvements were noted in pain, symptoms and disability for the chiropractic group compared to the group that did home exercises

7 Adding chiropractic manipulative therapy to standard medical care for patients with acute low back pain: results of a pragmatic randomized comparative effectiveness study.

Goertz CM, Long CR, Hondras MA, Petri R, Delgado R, Lawrence DJ, Owens EF, Meeker WC. Spine (Phila Pa 1976). 2013 Apr 15;38(8):627-34.

Summary: Adding chiropractic to standard medical care for back pain offers significant advantages

This study looked at health outcomes of active duty military personnel between the ages of 18 and 35 years of age with acute low back pain of less than 4 weeks duration. Treatments included chiropractic manipulative therapy plus standard medical care or standard medical care alone.

- Results found chiropractic plus standard medical care offers a **significant advantage for decreasing pain intensity, and improving physical function, satisfaction and perceived improvement** in military personnel compared to standard medical care alone
- 73% of participants in the standard medical care and chiropractic group rated their global improvement as pain completely gone, much better, or moderately better, compared with 17% in the standard medical group
- The average satisfaction with care score on a 0 to 10 scale was compared for the chiropractic care and the standard medical care (SMC) groups. The mean score for the chiropractic care group was 8.9 at both weeks 2 and 4; the mean score for the SMC group was 4.5 at week 2 and 5.4 at week 4

8 A randomized controlled trial comparing a multimodal intervention and standard obstetrics care for low back and pelvic pain in pregnancy.

George JW, Skaggs CD, Thompson PA, Nelson DM, Gavard JA, Gross GA. Am J Obstet Gynecol. 2012 Oct 23

Summary: Including chiropractic care with standard obstetric care benefits patients

- Including chiropractic interventions with standard obstetric care for low back and pelvic pain in mid pregnancy **benefits patients more than standard obstetric care alone**
- The benefits of adding chiropractic to standard obstetric care are both subjective and objective
- Chiropractic patients perceived less pain and disability and an overall global improvement in daily activities and their physical examinations revealed improved range of motion, stability, and less irritation at the lumbar and pelvic joints

Adding chiropractic manipulative therapy to standard medical care

Pain Improvement:

73%

in the standard medical care and chiropractic group

vs.

17%

in the standard medical care

Patient Satisfaction:

8.9

at both 2 and 4 weeks

vs.

4.5 & 5.4

at week 2 and 4 respectively

9 Early predictors of lumbar spine surgery after occupational back injury: results from a prospective study of workers in Washington State.

Keeney BJ, Fulton-Kehoe D, Turner JA, Wickizer TM, Chan KC, Franklin GM. Spine (Phila Pa 1976). 2013;38(11):953-64.

Summary: After back injury workers whose first visit was to a chiropractor had significantly lower odds of surgery

- Workers with an initial visit for the injury to a surgeon had almost nine times the odds of receiving lumbar spine surgery compared to those seeing primary care providers, whereas **workers whose first visit was to a chiropractor had significantly lower odds of surgery**
- About 43% of workers who first saw a surgeon had surgery within 3 years, in contrast to **only 1.5% of those who first saw a chiropractor**

10 Spinal manipulation, medication, or home exercise with advice for acute and subacute neck pain: a randomized trial.

Bronfort G, Evans R, Anderson AV, Svendsen KH, Bracha Y, Grimm RH. Ann Intern Med. 2012 Jan 3;156(1 Pt 1):1-10.

Summary: Chiropractic more effective than medication for adults with acute and subacute neck pain

Adults with current neck pain of 2 to 12 weeks' duration were randomized into 12 weeks of either chiropractic spinal adjustments, medication, or home exercise with advice.

- Chiropractic spinal adjustments and home exercise were **more effective than management with medication in both the short term and long term**
- Patients receiving chiropractic adjustments were **more satisfied with their care than either the home exercise group or the medication group**
- Participants in the medication group reported higher levels of medication use after the intervention

11 Consensus process to develop a best-practice document on the role of chiropractic care in health promotion, disease prevention, and wellness.

Hawk C, Schneider M, Evans MW, Jr., Redwood D. J Manipulative Physiol Ther. 2012;35(7):556-67.

Summary: Approach to wellness care and disease prevention in chiropractic practice

- A best-practice model for chiropractic wellness care emphasizes the following 3 components:
  a) **Manual procedures to promote optimal function and the ability to engage in an active lifestyle**
  b) Screening for risk factors for disease, such as tobacco use, lack of physical activity, and obesity
  c) Evidence-based health behavior counseling to promote health and prevent disease and injury, placing an emphasis on activities and dietary and lifestyle factors that promote optimal function

Patient Satisfaction with chiropractic care

83%

of patients were very satisfied or satisfied with their chiropractic care

14

12 Risk of traumatic injury associated with chiropractic spinal manipulation in Medicare Part B beneficiaries aged 66 to 99 years.

Whedon JM, Mackenzie TA, Phillips RB, Lurie JD. Spine (Phila Pa 1976). 2015;40(4):264-70.

Summary: Seniors have lowered risk of injury following chiropractic visit than medical visit

- Among Medicare beneficiaries aged 66 to 99 years with an office visit for a neuromusculoskeletal problem, risk of injury to the head, neck, or trunk within 7 days was **76% lower** among subjects with a chiropractic office visit than among those who saw a primary care physician
- The cumulative probability of injury in the chiropractic group was 40 injury incidents per 100,000 subjects compared with 153 incidents per 100,000 subjects in the primary care group

Early predictors of lumbar spine surgery

1.5% Did not see a chiropractor had surgery within 3 years

vs.

43% Did see a chiropractor had surgery within 3 years

9

13 Value of chiropractic services at an on-site health center.

Krause CA, Kaspin L, Gorman KM, Miller RM. J Occup Environ Med. 2012;54(8):917-21.

Summary: Lower health care use and improved functional status with on-site chiropractic care

- **On-site chiropractic services are associated with lower health care utilization and improved functional status of musculoskeletal conditions**
- Improved functional status indicates potential for reduced indirect costs, including absenteeism, presenteeism and productivity losses, with on-site chiropractic services
- The results of this study support the value of chiropractic services offered at on-site health centers

14 Factors associated with patient satisfaction with chiropractic care: survey and review of the literature.

Gaumer G. J Manipulative Physiol Ther. 2006;29(6):455-62.

Summary: Overall satisfaction among persons ever using chiropractic is very high

- Approximately **83% of patients were very satisfied or satisfied with their chiropractic care**
- Patients find that chiropractic appointments are prompt, waits are not too long, phone access is good and that chiropractors communicate well

15 Immediate effects of spinal manipulative therapy on regional antinociceptive effects in myofascial tissues in healthy young adults.

Srbely JZ, Vernon H, Lee D, Polgar M. J Manipulative Physiol Ther. 2013;36(6):333-41.

Summary: Chiropractic and immediate pain relief

- Spinal manipulation by a chiropractor provided **significant short-term improvements in pressure pain thresholds in young adults**
- The evidence supports further research into the potential benefit and role of chiropractic care in the management of chronic widespread pain syndromes including myofascial pain, and fibromyalgia

CT
Connecticut Chiropractic Association
www.ctchiro.com

2257 Silas Deane Highway | Rocky Hill, CT 06067
(860) 257-0404 | 1-800-966-BACK
www.ctchiro.com

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

Federal and Connecticut Insurance Laws for Chiropractic Coverage

1. Federal laws regulating chiropractic health care in CT

PPACA, Section 2706

Provider Non-Discrimination

PHS Act section 2706(a),[3] as added by the Affordable Care Act, states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law." PHS Act section 2706(a) does not require "that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer," and nothing in PHS Act section 2706(a) prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." Similar language is included in section 1852(b)(2) of the Social Security Act[4] and implementing HHS regulations.[5]

The statutory language of PHS Act section 2706(a) is self-implementing and the Departments do not expect to issue regulations in the near future. PHS Act section 2706(a) is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

For questions about the provider nondiscrimination provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272.

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

2. State laws regulating chiropractic health care in CT

Sec. 38a-479. Definitions. Contracting health organizations to establish procedure allowing physicians to view fee schedules. Fee information to be confidential. (a) As used in this section: (1) "Contracting health organization" means (A) a managed care organization, as defined in section 38a-478, or (B) a preferred provider network, as defined in section 38a-479aa; and (2) "physician" means a physician or surgeon, chiropractor, podiatrist, psychologist or optometrist.

Sec. 38a-479a. Physicians and managed care organizations to discuss issues relative to contracting between such parties. The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall convene, at least two times each year, a group of physicians and managed care organizations, to discuss issues relative to contracting between physicians and managed care organizations, including issues relative to any national settlement agreements, to the extent permitted under such settlement agreements.

Sec. 38a-507. Coverage for services performed by chiropractors. Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic services (1) treat a condition covered under such policy, and (2) are within those services a chiropractor is licensed to perform.

Sec. 38a-534. Coverage for services performed by chiropractors. Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6) and (11) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic services (1) treat a condition covered under such policy, and (2) are within those services a chiropractor is licensed to perform.

Sec. 38a-548. Penalty. Any insurer, hospital or medical service corporation, health care center or fraternal benefit society, or any officer or agent thereof, delivering or issuing for delivery to any person in this state any policy in violation of any of the provisions of sections 38a-512 to 38a-533, inclusive, 38a-537 to 38a-542, inclusive, and 38a-545, shall be fined not more than one thousand dollars for each offense, and the commissioner may revoke the license of any foreign or alien insurer, or any agent thereof, violating any of those provisions.

Sec. 38a-550a. Copayments re in-network physical therapy services and in-network occupational therapy services. No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall impose copayments that exceed a maximum of thirty dollars per visit for in-network (1) physical therapy services rendered by a physical therapist licensed under section 20-73, or (2) occupational therapy services rendered by an occupational therapist licensed under section 20-74b or 20-74c.

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

Sec. 38a-551. (Formerly Sec. 38-371). Definitions. For the purposes of this section and sections 38a-552 to 38a-559, inclusive, the following terms shall have the following meanings:
(a) "Health insurance" means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, health care center contracts and self-insured or self-funded employee health benefit plans. For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "health insurance" does not include (1) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (2) policies of specified disease or limited benefit health insurance, provided: (A) The carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; and (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policy in the state; and (B) for each such policy that is offered for the first time in this state on or after July 1, 2005, the carrier files with the commissioner the information and statement required in subparagraph (A) of this subdivision at least thirty days prior to the date such policy is issued or delivered in this state.
(b) "Carrier" means an insurer, health care center, hospital service corporation or medical service corporation or fraternal benefit society.
(c) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.
(d) "Health care center" means a health care center, as defined in section 38a-175.
(e) "Self-insurer" means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or any part of the cost of covered hospital or medical expenses for covered individuals. For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "self-insurer" shall not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization which is exempt from federal income taxes under the provisions of Section 501 of the United States Internal Revenue Code and amendments thereto and legal interpretations thereof, except any such organization described in Subsection (c)(15) of said Section 501.
(f) "Commissioner" means the Insurance Commissioner of the state of Connecticut.
(g) "Physician" means a doctor of medicine, chiropractic, naturopathy, podiatry, a qualified psychologist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry and, subject to the provisions of section 20-138d, optometrists duly licensed under the provisions of chapter 380.

Sec. 38a-553. (Formerly Sec. 38-373). Minimum standard benefits of comprehensive health care plans. Optional and excludable benefits. Preexisting conditions. Use of managed care plans. All individual and all group comprehensive health care plans shall include minimum standard benefits as described in this section.

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

Compliance of state mandates in the Affordable Care Act:

Sec. 8. Section 38a-591 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):
(a) For purposes of this section, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P. L. 111-148, as amended from time to time, and regulations adopted thereunder.
(b) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center licensed to do business in the state shall comply with Sections 1251, 1252 and 1304 of the Affordable Care Act and the following Sections of the Public Health Service Act, as amended by the Affordable Care Act: (1) 2701 to 2709, inclusive, 42 USC 300gg et seq. ; (2) 2711 to 2719A, inclusive, 42 USC 300gg-11 et seq. ; and (3) 2794, 42 USC 300gg-94.
(c) This section shall apply, on and after the effective dates specified in the Affordable Care Act, to insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers licensed to do business in the state.
(d) No provision of the general statutes concerning a requirement of the Affordable Care Act shall be construed to supersede a provision of the general statutes that provides greater protection to an insured, except to the extent the latter prevents the application of a requirement of the Affordable Care Act.
(e) (1) The Insurance Commissioner shall, within available appropriations, evaluate whether insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers subject to the Affordable Care Act are in compliance with the requirements under said act, including, but not limited to, the prohibition against discriminatory benefit designs. Any such company, society, corporation or center shall submit to the commissioner, upon request, the following information for a specific health insurance policy or plan: (A) The benefits covered under each of the categories of the essential health benefits package, as defined by the Secretary of Health and Human Services; (B) any coverage exclusions or restrictions on covered benefits, including under the prescription drug benefit; (C) any drug formulary used, the tier structure of such formulary and a list of each prescription drug on such formulary and its tier placement; (D) any applicable coinsurance, copayment, deductible or other out-of-pocket expenses for each covered benefit; and (E) any other information the commissioner deems necessary to evaluate such company, society, corporation or center.
(2) The commissioner shall report annually, within available appropriations, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance on any insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center evaluated pursuant to subdivision (1) of this section in the preceding year and the findings of such evaluation.

Sec. 38a-1086. Certification of health benefit plans. (a) The exchange may certify a health benefit plan as a qualified health plan if:
(1) The plan includes, at a minimum, essential benefits as determined under the Affordable Care Act and the coverage requirements under chapter 700c, except that the plan shall not be required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection (e) of this section, if:
(A) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and
(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that such plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the exchange;

UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

2016 Rate Review Hearings
Public Comment
August 3 & 4, 2016
Universal Health Care Foundation of Connecticut
Lynne Ide, Director of Program & Policy

Universal Health Care Foundation of Connecticut is submitting public comment on the proposed rate increases for Anthem, ConnectiCare and Aetna for both on and off-marketplace individual and small employer plans.

We understand that the Connecticut Insurance Department focuses on actuarial analysis and questioning of insurer assumptions when reviewing proposed rates. We understand that the Department is required to ensure the fiscal solvency of insurers via their rates. We also understand that that rate increases, especially double-digit increases, makes purchasing a health insurance plan for consumers a financial struggle, and threatens the fiscal solvency of many households. But while insurers have other products, investments, and streams of revenue to turn to, the consumer must rely on state regulators to protect them.

The Department has shown, in the past, a willingness to reduce rate requests if the insurer cannot justify the assumptions used in actuarial analysis. We are grateful that the Department does its due diligence and ensures that rates are not any higher than required.

What concerns us most, though, is that despite factual support for rate increases, those analyses are done in a vacuum that does not consider the impact of rates on consumers. If a plan is unaffordable, a consumer simply will either not purchase or choose a low-cost, high deductible plan. A small employer may shift higher premium costs to employees.

Unaffordable health insurance is a more expensive version of being uninsured. Having a health plan satisfies the individual mandate – but utilization of that health plan may be limited by higher cost-sharing, choosing a high deductible health plan, or how increased premiums eat into dollars that could have been spent on co-pays and other co-insurance.

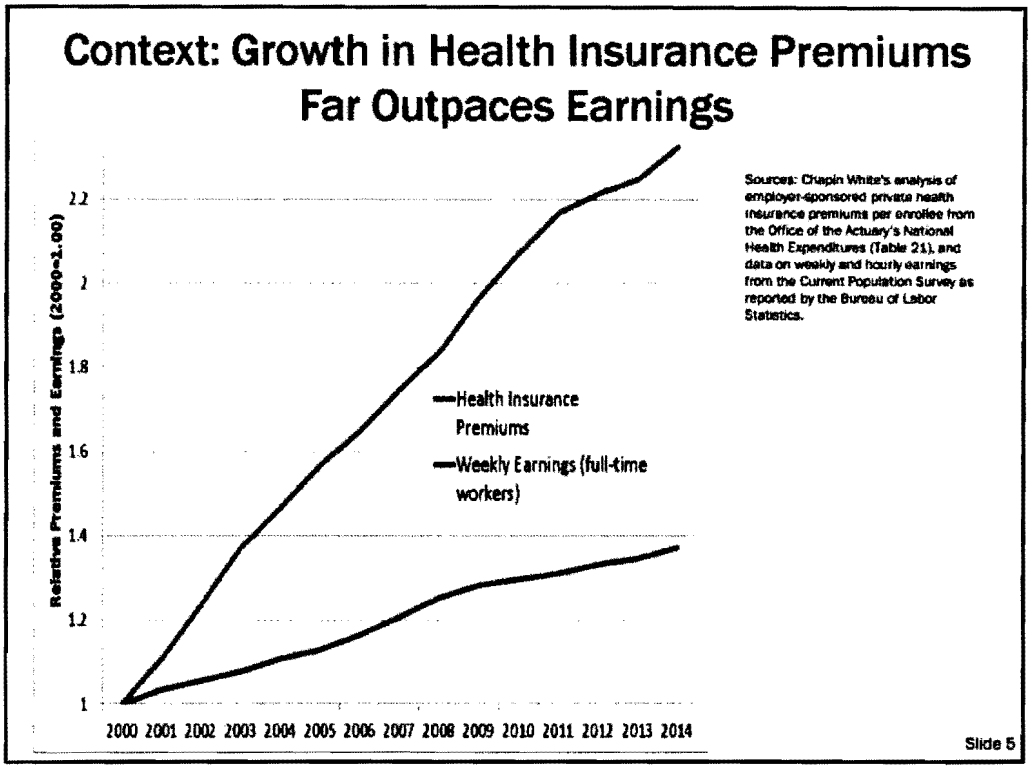
The bottom line is that health insurance costs are unsustainable for consumers and something has got to change. Our hope is that the Department will work with us to be part of the solution

Here are a few points to consider

1. **Health care costs keep rising.** The growth in the cost of premiums dwarfs the growth of earnings since 2000 (see diagram below[1]). Despite a slowdown in health care cost increases, 0costs are still rising, and are 17% of gross domestic product (GDP)[2]. In the July 2016 edition of

[1] Slide 5 from "Provider Consolidation" presentation by Chapin White of the RAND Corporation, hosted by the Consumers Union Health Care Value Hub, January 2016 (URL: http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-july-2016/)
[2] From "High Deductible Health Plans" Health Policy Brief from Health Affairs and the Robert Wood Johnson Foundation, February 4, 2016 (URL: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=152)

the Kaiser Health Tracking Poll, 38% of registered voters said that health care costs are a top health issue for them[3].



2. **The trends in high-deductible plans and increased cost-sharing are causing deferral of care, which contributes to higher health care costs down the road, and closing the door to needed care for too many.** In an effort to curb health care spending, insurers opt to offer high-deductible health plans. While these do show a reduction in cost, by lowering use of care[4], the net effect is that members are also using less health care than they need. In a Families USA Special Report, data showed that "one quarter of health care consumers with non-group insurance still have problems affording care.[5]

3. **Dwindling choice in the marketplace puts people in an even harder position.** With less choice and competition, insurers have less incentive to design and price plans that are centered on high-value care and affordability to the consumer.

   For example, the exit of Healthy CT from the market, the individual exchange leaves consumers with only two choices: ConnectiCare and Anthem. On the SHOP exchange, there is no choice –

---

[3] See Figure 7 in "Kaiser Health Tracking Poll: July 2016" by Ashley Kirzinger, Elise Sugarman & Mollyann Brodie from Kaiser Family Foundation, July 15, 2016 (URL: http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-july-2016/)

[4] From "High Deductible Health Plans" Health Policy Brief from Health Affairs and the Robert Wood Johnson Foundation, February 4, 2016 (URL: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=152)

[5] See Page 5 in "Non-Group Health Insurance: Many Insured Americans with High Out-of-Pocket Costs Forgo Needed Health Care" from Families USA, May 2015 (URL: http://familiesusa.org/sites/default/files/product_documents/ACA_HRMSurvey%20Urban-Report_final_web.pdf)

Anthem is the only insurer. **This limit in choice in the exchange markets makes the rate increase requests even more critical for consumers.**

Despite Department of Justice action to block the Anthem-Cigna merger[6], we are also deeply concerned that this merger will only exacerbate the problem of choice and competition, pushing quality, affordable health insurance out of reach for more and more residents of the state.

4. **We come to the conclusion that affordability must become part of the Department's charge.** We need affordability standards against which rate hikes are evaluated. The Department must be charged with looking out for us all, not only the viability of the insurers.

   We need only look to nearby Rhode Island, for a prime example of a state where affordability standards are a formal element of rate review. In Rhode Island, the legislature created a standalone Office of the Health Insurance Commissioner in 2004, which was essentially a legislative mandate to address affordability. In 2010, the Commissioner, through a public process, generated the first version of affordability standards, which were later refined in 2015 after assessment and evaluation of the first set of standards[7].

We have hundreds of petition signatures to submit into the hearing record today. These consumers represent the tip of the iceberg of everyday people who need and want our state's regulators to look out for them, too.

We are in full support of the testimony provided by the Office of the Healthcare Advocate by Demian Fontanella. We exhort you to consider the questions Mr. Fontanella raises about the three insurers that are the focus of rate hike hearings today and tomorrow (Anthem, ConnectiCare, and Aetna).

The key points raised in his comment—that rising premium costs and out-of-pocket expenses for consumers makes health insurance plans both financially challenging to purchase, and then use—are critical factors to consider for the consumer. We echo and support Mr. Fontanella's request that the Connecticut Insurance Department "exercise your authority to make a meaningful impact on Connecticut's healthcare system.[8]"

---

[6] See "U.S. Suing to Block Aetna-Humana and Anthem-Cigna Mergers" from the Hartford Courant by Mara Lee & Stephen Singer, July 21, 2016 (URL: http://www.courant.com/business/hc-anthem-cigna-20160721-story.html)

[7] See Slides 9-30 in "Study of Cost Containment Models and Recommendations for Connecticut: Review of Rhode Island and Massachusetts" compiled by Bailit Health for the Connecticut State Health Care Cabinet Cost Containment Study, March 8, 2016 (URL: http://portal.ct.gov/Departments_and_Agencies/Office_of_the_Lieutenant_Governor/HCC/PDF_Files/HCC_030816_Presentation/)

[8] From the Connecticut State Office of the Healthcare Advocate Comments for 2016 Rate Review (URL: http://www.ct.gov/cid/lib/cid/OHA-2016RateReviewTestimony.pdf)

2016 Rate Review Hearings
August 3-4, 2016
Public Comment Submitted By Ann Hagman

Years ago, before the health exchange, I wrote to the health insurance department and questioned the high rate increases, but the answer I got was very impersonal and standardized. They justified their approval of the rate increases and sent me a list of health insurance companies that I could contact. Needless to say, it was of no help.

I was very happy when I got my health insurance, ConnectiCare through the exchange. Then the total mess started. I had changed from Silver to Gold and ConnectiCare told me to start using the Silver card, and once they mailed me the Gold card, ConnectiCare would adjust all dollar amounts.

Let me tell you, ConnectiCare never did that, and the Exchange missed sending the information about my tax credit to ConnectiCare, so ConnectiCare kept mailing me bills without tax credit adjustments. Meanwhile, many of my doctors STOPPED accepting ConnectiCare plans through the exchange.

I was very upset and got sick from all this crazy friction between all parties. That was when I switched to Healthy CT. At least my doctors accepted their plans and they got the billing right from the exchange. But ConnectiCare kept sending me bills and later sent me an incorrect tax from, so I had to contact the exchange numerous times to get a correction, but not until I spoke with a person that handled the tax forms did it get corrected, which was over a year later.

Now you are telling me that I cannot get Healthy CT through the exchange. I have only two choices, really only one, since I never can trust ConnectiCare again. Somehow, I have the feeling that all plans coming through the exchange will be "marked" and only a few doctors will be willing to accept them. With other words, there will be a sorting and labeling of (poor) patients, and we all know what that means. I don't think that was the intentions with the ACA, but somehow interest groups in Washington, with all their profits from "health" care, got it their way.

I would LOVE to have universal healthcare - that would be HEALTH CARE accepted by doctors - no layer of middlemen, and not depending on jobs or location.

To: Commissioner Katharine Wade

I am writing to ask the Insurance Department to consider the impact of the proposed rate increases on everyday people like me. It is outrageous that some insurers are asking for double-digit increases! How can working families and small businesses afford that? It's time our state steps in and protects the people struggling to pay for their health care. With fewer choices in the health insurance marketplace, we think you should use everything in your power to make sure affordability to the consumer is the focus of rate review.

First name	Last name	Zip code	Comments	Timestamp (EST)
Nadine	Alexander	06516	I work full time and am scratching by but pay for insurance, rent, food,etc. I find great clothes at Savers and Good Will to make sure my books can balance. PLEASE do NOT make it harder with higher insurance costs! Sincerely, Nadine Alexander	2016-08-02 16:10:08 EST
Anne-Marie	Vogt	06784	Please do not raise our insurance rates. My family and I can not afford any further increases. Sadly, we will be forced out of our home and possibly the state if further increases occur. Please do not approve these increases. My husband and I work full time as nurses. Our salaries have not increased to offset the past increases, let alone any future increases.	2016-08-02 16:14:45 EST
Susan	Hewes	06280		2016-08-02 16:15:36 EST
Kathleen Ava G	Cruz	06483		2016-08-02 16:33:46 EST
Lynn	Willie	06470		2016-08-02 16:50:15 EST
Frances	Wood	06854	Do NOT raise insurance rates!	2016-08-02 16:55:21 EST
Scott	Morese	06776		2016-08-02 16:56:13 EST
Sara	Arteaga	06811		2016-08-02 17:01:38 EST
Margaret and Patricia	Sellers/Deviine	06255		2016-08-02 17:23:54 EST
Lorraine	Reid	06457	Please don't hike the insurance, I can just about afford what I have now.	2016-08-02 17:33:36 EST
Linda	Najam	06811		2016-08-02 17:39:44 EST
Joann	Koch	06249		2016-08-02 17:55:35 EST
Alicia	Fanciulli	06484		2016-08-02 17:55:28 EST
Michalan	Sheehan	06810		2016-08-02 18:01:21 EST
Barbara	Imp	06798	that is awful	2016-08-02 18:27:04 EST
Dawn	Furniss	06804	I cannot afford an insurance rate increase. I am an RN working in the healthcare system and already pay an exorbitant amount of money for insurance. Please do not consider the insurance companies request to increase rates.	2016-08-02 18:32:57 EST
Yvette	Larrieu	06405		2016-08-02 18:46:04 EST
Grayson	Craddock	06605		2016-08-02 19:11:58 EST
Regina	Petaway	06457		2016-08-02 19:15:43 EST

Amanda	Huthins Warren	06896	The people of CT cannot ride this increase without huge hardship.	2016-08-02 19:23:53 EST
Susan	Kessler	06801		2016-08-02 19:26:12 EST
Ellen	Bowen	06905		2016-08-02 19:41:54 EST
James	Root	06810	Let's find another way.	2016-08-02 20:04:43 EST
Luann	Sullivan	06470		2016-08-02 20:13:39 EST
Damion	Toran	06770	Please do not raise our cost for healthcare. We are already struggling.	2016-08-02 20:16:18 EST
diane	matta	06371		2016-08-02 20:43:34 EST
Marie	McTigue	06371		2016-08-02 20:46:40 EST
Randi	Saslow	06514		2016-08-02 20:46:36 EST
Janet	Taveras	10708		2016-08-02 20:57:29 EST
Jane	Platt	06461		2016-08-02 21:13:55 EST
Richard N.	Platt, Jr.	06461		2016-08-02 21:14:50 EST
Nancy	Scott	10512		2016-08-02 21:18:41 EST
Kristin	McKay	06776	Please do not raise rates. Trying to stay in the middle class. Most concerned about maintaining opportunities for my children. This becomes difficult when the cost of basic needs shoot up.	2016-08-02 21:31:45 EST
Janice	Stauffer	06896	We can not afford any more TAXES, we will be forced to move out of this State. PLEASE lower our taxes and let us live with some dignity!!!!!!	2016-08-02 21:42:24 EST
Carmen	Hernandez	06706		2016-08-02 22:14:23 EST
Kevin	Berrill	06488		2016-08-02 22:51:24 EST
Leodie	Salazar	06804	Current rates are already high and unaffordable for the majority,	2016-08-02 23:10:07 EST
sharon	Bunney	06470		2016-08-02 23:13:08 EST
Alessandra	DeCarvalho	06812		2016-08-02 23:19:50 EST
Diana	Leone	10512		2016-08-02 23:36:37 EST
Philip	Dooley	06084		2016-08-03 02:28:30 EST
mary	rozzi	06488		2016-08-03 04:46:03 EST
Anne	Hulick	06416		2016-08-03 07:21:58 EST
Amy	Marwood	06268		2016-08-03 08:07:37 EST
Amy	Marwood	06268		2016-08-03 08:07:38 EST
Mark	Kosnoff	06450		2016-08-03 08:47:44 EST
Margaret	Boulanger	06784		2016-08-03 09:12:27 EST

Mark	Skaret	06065		2016-08-03 09:17:05 EST
Lori	Bergen	06776		2016-08-03 09:37:35 EST
Susan	Hill	06811		2016-08-03 09:54:55 EST
Hannah	Roditi	06002		2016-08-03 09:57:09 EST
Cathy	Hunt	06804		2016-08-03 10:49:08 EST
Tracy	Oldakowski	06776	The people of Connecticut cannot afford medical cost increases! These insurance companies must be regulated/controlled	2016-08-03 11:08:03 EST
Donna	Riggio	06784		2016-08-03 13:26:11 EST
Christine	Dunster	06903		2016-08-03 14:44:50 EST
Lisa	Freeman	06824		2016-08-03 15:23:05 EST

1 in 4 adults with non-group coverage went without some needed health care because they could not afford the cost.*

Types of health care that adults with non-group coverage went without (by percent of adults)*

Tests, treatment, or follow-up care — 15%

Prescription drugs — 14%

Medical care — 12%

General doctor — 12%

Specialist — 11%

*Adults who were insured for the past 12 months and had to forgo care in the past 12 months.

Source: Families USA analysis of Urban Institute HRMS, September and December 2014

www.FamiliesUSA.org

Commissioner Katharine Wade
Connecticut State Insurance Department
153 Market St.
Hartford, CT 06103

Subject: Comments regarding Insurance Rate Increase Requests for 2017

We are required to have health ins. coverage - we were told it would be affordable, perhaps for those receiving subsidies, but not for those who do not. the insurance companies can't use "raise rates" mentality as the regular default for "solving" their income problems.

All must be more conscious of the need to be more creative - cut/reduce instead of constantly raising rates, taxes, etc.

Increases cannot exceed current inflation rates.

Increases at proposed rates are unacceptable & cannot be approved with the expectation residents will continue to remain in CT.

We know Obamacare isn't working. How is the plan the federal employees have working? Why can't that plan be used as a model for the taxpayers who pay for that plan as well as their own ACA compliant plan?

Name: Beth Love

Address: 300 Sound Street, Fairfield CT

Phone: 203.259.8225

EMail: jhlove@snet.net

Commissioner Katharine Wade
Connecticut State Insurance Department
153 Market St.
Hartford, CT 06103

Subject: Comments regarding Insurance Rate Increase Requests for 2017

To Commissioner

At 52 yrs old and married 22 yrs. My wife and I just discussed dropping health care completely and taking our chances. Connecticare is asking for a 29% increase. A 1% increase is completely at the question. We are now at the Unaffordable peak of costs.

Thank You Thomas Saucier

Name: Thomas Saucier

Address: 1832 North Benson Rd

Phone: 203-209-2362

EMail: HRDWRKTom@AOL.Com

Commissioner Katharine Wade
Connecticut State Insurance Department
153 Market St.
Hartford, CT 06103

Subject: Comments regarding Insurance Rate Increase Requests for 2017

Insurance costs are prohibitive and are driving paying customers out of the system.

Name: Joseph ANANIA

Address: 41 Vesper St Fairfield CT

Phone: 203 3346233

EMail:

CTChiro
Connecticut Chiropractic Association

Commissioner Katharine L. Wade
Connecticut Department of Insurance
153 Market Street
Hartford, CT 06103

August 3, 2016

Re: Health Insurance Rate Increase

Commissioner Wade,

My name is Dr. Richard Duenas and I am the president of the Connecticut Chiropractic Association. I am here to address proposed insurance rate increases for Anthem Health Plans, Aetna Life Insurance Company and ConnectiCare Insurance Company, and to share our concerns about policies established by these companies that reduce the full scope of chiropractic practice as allowed by law thus compromising patient rights to select their chiropractic physician for their general, primary and specialty health care needs.

The Connecticut chiropractic scope of practice authorizes chiropractic physicians to provide comprehensive whole person diagnosis and management of the individual's state of health without the use of drugs or surgery. Since the inception of the profession in 1895 and licensure in Connecticut in 1917, patients have utilized their chiropractic physician for their primary health care and specialty health care needs. The profession espouses natural methods of health care and has demonstrated exceptional, safe and effective results for primary and specialty care services usually at costs less than medically provided care and often with better clinical outcomes. Patient satisfaction for chiropractic care is usually superior to other methods of care. Chiropractic physicians are qualified by training, state and federal law to provide physician level services including physical examinations, consultations, diagnostics, physical medicine, diet and nutrient services and products, preventive and wellness health care and the prescription and provision of durable medical goods. Unfortunately, as insurance companies are consolidating and establishing more managed care in order to control their expenses, we have witnessed the liberties of patients to choose their provider and utilize a chiropractor instead of a medical doctor, and the ability of chiropractic physicians to provide the full scope of chiropractic services to these patients more restrained. To make matters worse, we recognize the insurance laws that require coverage of chiropractic services to the same extent as coverage is provided by medical doctors and prohibit discrimination against all providers are often ignored by the insurance companies.

We have heard these insurance companies represent that they are in compliance with the Patient Protection and Affordable Care Act (PPACA) for Exchange and Non-Exchange Plans in their Executive Summaries. We disagree. Federal law, Patient Protection and Affordable Care Act - section 2706, specifically prohibits health care provider discrimination. Connecticut statute section 38a-591 specifically requires all plans sold on the Exchange follow PPACA - section 2706 and also the state's mandates. In the state's mandates for individual and group health plans, Section 38-504 and section 38-534 specifically require insurers to cover chiropractic services to the same extent as coverage is provided for medical services.

In our experiences and upon review of insurance plan policies sold on and off the

Exchange, we find health insurance plans, including Anthem Blue Cross Blue Shield, Aetna and ConnectiCare, to be in violation of Section 2706 of the PPACA and in violation with Sections 38-504 and 38-534 of Connecticut statutes in the following ways:

- No company presents chiropractic physicians to subscribers and potential patients to the same extent as medical doctors are presented. This steers patients into medical practices and improperly restrains the fair trade of the healing arts.
- All plans impose limits to chiropractic physical treatments when no such limits are imposed upon medical physical treatments. This increases the costs burden of patients.
- Most plans ascribe chiropractic physicians as specialists which causes higher co-payments imposed upon patients. A more reasonable, realistic and traditional role to ascribe the chiropractic physician is as a primary care physician or generalist. This categorization is associated with a much lower co-payment for examination and consultation services.
- One company offers a reimbursement policy to chiropractic physician's that is non-congruent with reimbursement policy offered to medical doctors. The policy offered to chiropractic physicians limits payment of services to a per diem rate. Thus, a time limit is imposed upon the chiropractic physician. The reimbursement policy offered to a medical doctor is based upon each service provided. There is no time limit imposed upon medical doctors. Thus, the MD is reimbursed for each service provided. Each service is coded to account for the service level of skill and time to deliver the service. Thus, the coverage for chiropractic services cannot be covered to the same extent as coverage is provided for medical services. Patients are harmed by this policy.

There is ample data to demonstrate chiropractic services do not increase costs to consumers, insurers and the health care system in general. In fact a study where the full scope of chiropractic care was utilized in Blue Cross Blue Shield of Illinois policies where patients utilized their chiropractors as their Primary Care Physician demonstrated the following results:

- 60% decrease in in-hospital admissions
- 59% decrease in hospital days
- 62% decrease in outpatient surgeries and procedures
- 85% decrease in pharmaceutical costs

With results like these you would expect all insurance companies, especially Anthem Blue Cross Blue Shield, to proactively recruit more chiropractic physicians into their plans with policies and a reimbursement schedule that allows the doctor to provide their full scope of practice and also promote the full scope of chiropractic services to their subscribers and hospitals. This is not so. It is just the opposite where their policies limit exposure to chiropractic care and they offer reimbursement schedules that prohibit the delivery of the full scope of chiropractic practice thus forcing patients into pharmaceutical approach of health care and higher costs. One has to wonder insurance company motives for raising premiums if they ignore proven methods of delivering health care more cost-effectively.

It is therefore our position that no insurance rates be raised until the insurance companies change their policies to be in compliance with federal and state laws. Such legal compliance is within the purview of the Department of Insurance. We believe other government regulators should be involved including the Attorney General's office, Office of Health Care Access, Comptroller's office, Department of Public Health and Access

Health Connecticut. We believe the Department of Insurance must rely upon the opinions and approval from organizations representing the medical, chiropractic, naturopathic, podiatric, optometry, behavioral health and advanced practice registered nursing professions to authorize compliance of state and federal laws.

We have attached documents supporting our statements. We are always available to discuss these issues further and look forward to working the Department of Insurance, insurance companies, government regulators, legislators and patient advocacy organizations to assure patient liberties in the health care system are protected and all providers can practice to the full extent of their license.

Thank you,

Richard Duenas, D.C.
President
Connecticut Chiropractic Association

Attachments
Copy: file

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

Federal and Connecticut Insurance Laws for Chiropractic Coverage

1. Federal laws regulating chiropractic health care in CT

PPACA, Section 2706

Provider Non-Discrimination

PHS Act section 2706(a),[3] as added by the Affordable Care Act, states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law." PHS Act section 2706(a) does not require "that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer," and nothing in PHS Act section 2706(a) prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." Similar language is included in section 1852(b)(2) of the Social Security Act[4] and implementing HHS regulations.[5]

The statutory language of PHS Act section 2706(a) is self-implementing and the Departments do not expect to issue regulations in the near future. PHS Act section 2706(a) is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

For questions about the provider nondiscrimination provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272.

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

2. State laws regulating chiropractic health care in CT

Sec. 38a-479. Definitions. Contracting health organizations to establish procedure allowing physicians to view fee schedules. Fee information to be confidential. (a) As used in this section: (1) "Contracting health organization" means (A) a managed care organization, as defined in section 38a-478, or (B) a preferred provider network, as defined in section 38a-479aa; and (2) "physician" means a physician or surgeon, chiropractor, podiatrist, psychologist or optometrist.

Sec. 38a-479a. Physicians and managed care organizations to discuss issues relative to contracting between such parties. The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall convene, at least two times each year, a group of physicians and managed care organizations, to discuss issues relative to contracting between physicians and managed care organizations, including issues relative to any national settlement agreements, to the extent permitted under such settlement agreements.

Sec. 38a-507. Coverage for services performed by chiropractors. Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic services (1) treat a condition covered under such policy, and (2) are within those services a chiropractor is licensed to perform.

Sec. 38a-534. Coverage for services performed by chiropractors. Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6) and (11) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic services (1) treat a condition covered under such policy, and (2) are within those services a chiropractor is licensed to perform.

Sec. 38a-548. Penalty. Any insurer, hospital or medical service corporation, health care center or fraternal benefit society, or any officer or agent thereof, delivering or issuing for delivery to any person in this state any policy in violation of any of the provisions of sections 38a-512 to 38a-533, inclusive, 38a-537 to 38a-542, inclusive, and 38a-545, shall be fined not more than one thousand dollars for each offense, and the commissioner may revoke the license of any foreign or alien insurer, or any agent thereof, violating any of those provisions.

Sec. 38a-550a. Copayments re in-network physical therapy services and in-network occupational therapy services. No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall impose copayments that exceed a maximum of thirty dollars per visit for in-network (1) physical therapy services rendered by a physical therapist licensed under section 20-73, or (2) occupational therapy services rendered by an occupational therapist licensed under section 20-74b or 20-74c.

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

Sec. 38a-551. (Formerly Sec. 38-371). Definitions. For the purposes of this section and sections 38a-552 to 38a-559, inclusive, the following terms shall have the following meanings:
(a) "Health insurance" means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, health care center contracts and self-insured or self-funded employee health benefit plans. For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "health insurance" does not include (1) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (2) policies of specified disease or limited benefit health insurance, provided: (A) The carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; and (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policy in the state; and (B) for each such policy that is offered for the first time in this state on or after July 1, 2005, the carrier files with the commissioner the information and statement required in subparagraph (A) of this subdivision at least thirty days prior to the date such policy is issued or delivered in this state.
(b) "Carrier" means an insurer, health care center, hospital service corporation or medical service corporation or fraternal benefit society.
(c) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.
(d) "Health care center" means a health care center, as defined in section 38a-175.
(e) "Self-insurer" means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or any part of the cost of covered hospital or medical expenses for covered individuals. For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "self-insurer" shall not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization which is exempt from federal income taxes under the provisions of Section 501 of the United States Internal Revenue Code and amendments thereto and legal interpretations thereof, except any such organization described in Subsection (c)(15) of said Section 501.
(f) "Commissioner" means the Insurance Commissioner of the state of Connecticut.
(g) "Physician" means a doctor of medicine, chiropractic, naturopathy, podiatry, a qualified psychologist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry and, subject to the provisions of section 20-138d, optometrists duly licensed under the provisions of chapter 380.

Sec. 38a-553. (Formerly Sec. 38-373). Minimum standard benefits of comprehensive health care plans. Optional and excludable benefits. Preexisting conditions. Use of managed care plans. All individual and all group comprehensive health care plans shall include minimum standard benefits as described in this section.

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

Compliance of state mandates in the Affordable Care Act:

Sec. 8. Section 38a-591 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):
(a) For purposes of this section, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P. L. 111-148, as amended from time to time, and regulations adopted thereunder.
(b) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center licensed to do business in the state shall comply with Sections 1251, 1252 and 1304 of the Affordable Care Act and the following Sections of the Public Health Service Act, as amended by the Affordable Care Act: (1) 2701 to 2709, inclusive, 42 USC 300gg et seq. ; (2) 2711 to 2719A, inclusive, 42 USC 300gg-11 et seq. ; and (3) 2794, 42 USC 300gg-94.
(c) This section shall apply, on and after the effective dates specified in the Affordable Care Act, to insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers licensed to do business in the state.
(d) No provision of the general statutes concerning a requirement of the Affordable Care Act shall be construed to supersede a provision of the general statutes that provides greater protection to an insured, except to the extent the latter prevents the application of a requirement of the Affordable Care Act.
(e) (1) The Insurance Commissioner shall, within available appropriations, evaluate whether insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers subject to the Affordable Care Act are in compliance with the requirements under said act, including, but not limited to, the prohibition against discriminatory benefit designs. Any such company, society, corporation or center shall submit to the commissioner, upon request, the following information for a specific health insurance policy or plan: (A) The benefits covered under each of the categories of the essential health benefits package, as defined by the Secretary of Health and Human Services; (B) any coverage exclusions or restrictions on covered benefits, including under the prescription drug benefit; (C) any drug formulary used, the tier structure of such formulary and a list of each prescription drug on such formulary and its tier placement; (D) any applicable coinsurance, copayment, deductible or other out-of-pocket expenses for each covered benefit; and (E) any other information the commissioner deems necessary to evaluate such company, society, corporation or center.
(2) The commissioner shall report annually, within available appropriations, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance on any insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center evaluated pursuant to subdivision (1) of this section in the preceding year and the findings of such evaluation.

Sec. 38a-1086. Certification of health benefit plans. (a) The exchange may certify a health benefit plan as a qualified health plan if:
(1) The plan includes, at a minimum, essential benefits as determined under the Affordable Care Act and the coverage requirements under chapter 700c, except that the plan shall not be required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection (e) of this section, if:
(A) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and
(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that such plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the exchange;

CTChiro

Connecticut Chiropractic Association

ctchiro.com

Research Regarding the Cost-Effectiveness and Clinical Outcomes of Chiropractic Care

Summary of Findings

- A patient receiving regular chiropractic care experiences reduced hospital admissions, surgeries, and pharmaceutical costs.
- Studies indicate that greater chiropractic coverage, despite increased visits to a DC, results in significant net savings in both indirect and direct costs.
- Chiropractic care could reduce Medicare costs--both payment for all services and average per claim payment.
- Chiropractic students are better prepared to address musculoskeletal issues than medical students and most doctors.
- Chiropractic patients typically pay less and are more satisfied with their treatment than MD patients.
- Chiropractic care can be used to control health care costs.
- Chiropractic patients reach maximum medical improvement sooner than when treated by a medical doctor.

"My research, conducted over a ten-year period utilizing clinical and cost outcomes data from one of the nations largest insurance underwriters, suggests that the regular utilization of chiropractic could reduce the need for hospitalization, pharmaceutical usage and overall global health care costs by almost 50 percent."

- Richard I. Sarnat, M.D., President of Alternative Medicine Integration (AMI)

Examine the Research for Yourself

1. The Alternative Medicine Integration Study. Journal of Manipulative and Physiological Therapeutics, May 2007. Study results available at: www.jmptonline.org/article/S0161-4754(07)00076-0/abstract.

- The Alternative Medicine Integration Study was updated in 2007, covering the years of 2003-05. Results of the original study were confirmed.
- Chiropractic care patients demonstrated:
  - 60% decrease in in-hospital admissions
  - 59% decrease in hospital days
  - 62% decrease in outpatient surgeries and procedures
  - **85% decrease in pharmaceutical costs**

---

2. Clinical and Cost Outcomes of an Integrative Medicine IPA. Sarnat, Richard; Winterstein, James. Journal of Manipulative and Physiological Therapeutics 2004; 27: 336-347.

- In 1999, a large Chicago HMO began to utilize doctors of chiropractic (DCs) in a primary care provider role.
- During the 4-year study, this integrative medical approach, emphasizing a variety of complimentary and alternative medical (CAM) therapies, resulted in lower patient costs and improved clinical outcomes for patients.
- The patients who went to DCs as their primary care providers had:
  - 43% decrease in hospital admissions
  - 52% reductions in pharmaceutical costs
  - **43% fewer outpatient surgeries and procedures**

---

3. Enhanced Chiropractic Coverage Under OHIP (Ontario Health Insurance Plan) as a Means for Reducing Health Care Costs, Attaining Better Health Outcomes, and Achieving Equitable Access To Health Services. Manga, Pran. Report to the Ontario Ministry of Health, 1998.

- Demonstrates deterrence of the use of chiropractic care because it is not covered under OHIP.
- Authors indicate that greater chiropractic coverage under OHIP would result in a greater number of individuals visiting chiropractors and more frequent visits.
- Study shows that, despite increased visits to DCs, a net savings in both direct and indirect costs would be experienced. **Direct savings for Ontario's health care system would range between $380-770 million.**

---

4. Utilization, Cost, and Effects Of Chiropractic Care On Medicare Program Costs. Muse and Associates. American Chiropractic Association 2001.

- Examines cost, utilization, and effects of chiropractic services on Medicare costs.
- Compares program payments and service utilization for Medicare beneficiaries who visited DCs and those who visited other types of physicians.
- Results indicate that chiropractic care could reduce Medicare costs.
- **Average Medicare payment (all services) for beneficiaries who had chiropractic care: $4,426.**
  Average Medicare payment (all services) for beneficiaries who had other types of care: $8,102.
- The per claim average payment was also lower: $133 vs. $210.

---

5. Cost of Care for Common Back Pain Conditions Initiated with Chiropractic Doctor vs. Medical Doctor/Doctor of Osteopathy as First Physician: Experience of One Tennessee-Based General Health Insurer. Richard L. Liliendahl, M.D.; Michael D. Finch,

Ph.D.; David Axnene, FSA; Christine M. Goertz, EC, Ph.D. Journal of Manipulative and Physiological Therapeutics. Vol. 33, Issue 9.

- **Paid cost for episodes of care initiated with a DC were almost 40% less** than episodes initiated with an MD.
- Even after risk adjusting each patient's cost, episodes of care initiated with a DC were 20% less expensive than those initiated with an MD.

---

6. An Examination of Musculoskeletal Cognitive Competency in Chiropractic Interns. Humphreys, B.K.; Sulkowski, A.; Mc Intyre, K.; Kasiban, M.; Patrick, A.N. Journal of Manipulative Physiological Therapeutics 2007 Jan; 30(1):44-9.

- Prior studies have concluded that musculoskeletal medical education is inadequate; yet, musculoskeletal complaints are one of the most common reasons for seeking physician care.
- This study compared the results of 154 fourth-year chiropractic interns that completed the Basic Competency Examination in musculoskeletal medicine.
- Most interns passed the test with results that were considerably better than those of recent medical graduates and physical therapy doctorate students. The chiropractic intern scores were also higher than those of orthopedic staff physicians.
- **The 51%-64% success rate of chiropractors was almost double the 20%-30% rate of medical students and doctors.**

---

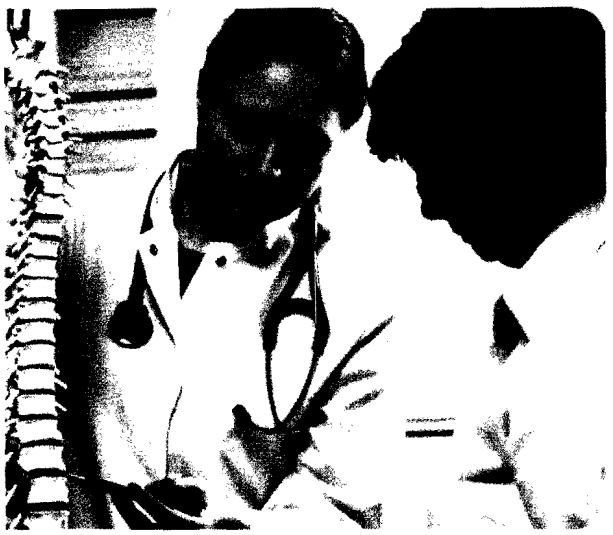
7. Costs and Recurrences of Chiropractic and Medical Episodes of Low Back Care. Smith, M.; Stano, M. Journal of Manipulative and Physiological Therapeutics 1997; 20(1): 5-12.

- Compares the health insurance payments and patient utilization patterns of individuals suffering from recurring low back pain who visited DCs or MDs.
- Insurance payments were higher for medically initiated episodes.
- **Those who visited chiropractors paid less and were more satisfied with the care given.**
- The study suggests that chiropractic care should be given careful attention by employers when using gate-keeper strategies.

---

8. Chiropractic and Medical Costs of Low Back Care. Stano, M., Smith, M. Medical Care 1996; 34(3): 191-204.

- Compares health insurance payments and patient utilization patterns for episodes of care for common lumbar and low back conditions treated by chiropractic and medical providers (uses 2 years of insurance claims data and examines more than 6,000 patients who had episodes with medical or chiropractic first-contact providers).
- Total insurance payments were substantially greater for episodes with a medical first-contact provider. **(Mean total payment was $1,020 with an MD vs. $518 with a DC.)**



9. Stano, Miron. The Economic Role of Chiropractic Further Analysis of Relative Insurance Costs for Low Back Care. Journal of the Neuromusculoskeletal System 1995; 3(3): 139-144.

- This retrospective study of 7,000+ patients compared costs of care for common low back conditions when a DC was used versus an MD as the first provider.
- Payments for inpatient procedures were higher for MD-initiated treatment, especially for episodes that lasted longer than one day.
- Outpatient payments were nearly 50% higher for MD-initiated treatments as well.
- **The author concluded that chiropractic care could help to control health care spending.**

10. Lost Productive Time and Cost Due to Common Pain Conditions in the U.S. Workforce. Stewart, W.F.; Ricci, J.A.; Chee, E.; Morganstein, D.; Lipton, R. Journal of the American Medical Association 2003. Nov 12; 290(18): 2443-54.

- Researchers questioned 29,000 respondents regarding the cost implications of reduced performance due to headaches, arthritis, back pain, and other musculoskeletal pain.
- Participants also responded as to whether common pain conditions had caused them to lose concentration, repeat jobs, do nothing, or feel fatigued at work.
- **The cost of lost productive time in the U.S. workforce was found to be $61 billion, and 76% of that cost was attributed to health-related reduced performance.**
- Data revealed that 1.1% of the workforce were absent one or more days per week because of common pain conditions.

---

11. Comparative Analysis of Individuals With and Without Chiropractic Coverage. Legorreta, A.; Metz, D.; Nelson, C.; Ray, S.; Chernicoff, H.; DiNubile, N. Archives of Internal Medicine 2004; 164: 1985-1992.

- A 4-year retrospective review of claims from 1.7 million health plan members were analyzed to determine the cost effects of the inclusion of a chiropractic benefit in an HMO insurance plan.
- Members with a chiropractic benefit had lower overall total annual health care costs.
- Back pain patients with chiropractic coverage also realized lower utilization of plain radiographs, low back surgery, hospitalizations and MRIs.
- **Back pain episode-related costs were 25% lower for those with chiropractic coverage ($289 vs. $399).**

---

12. Cost Comparisons of Chiropractic Care Versus Other Health Care Provider. Texas Workers' Compensation Report.[1]

"The average cost of [low back injury] claims is $15,884. **When a worker with a lower back injury receives at least 75% of his/her care from a chiropractor, that cost decreases to $12,202** and **when he/she receives at least 90% of their care from a chiropractor the average cost declines even further to $7,632.**"

[1] MGT of America, Inc. Chiropractic Treatment of Workers' Compensation Claimants in the State of Texas (Austin, Texas: 2003).

---

13. Chiropractic Care of Florida Workers' Compensation Claimants: Access, Costs, and Administrative Outcome Trends from 1994 to 1999. Folsom, B.L.; Holloway, R.W. Topics in Clinical Chiropractic 2002; 9(4): 33-53.

- Study revealed that average total cost for low-back cases treated medically was $16,998, while chiropractic care was only $7,309.
- Patients treated primarily by chiropractors were found to **reach maximum medical improvement almost 28 days sooner** than if treated by a medical doctor.
- Considerable cost savings and more efficient claims resolution may be possible with greater involvement of chiropractic treatment in specific low back cases and other specific musculoskeletal cases.

---

14. FYI-IPA. Gemmell, H.A., Hayes, B.M. Patient Satisfaction with Chiropractic Physicians in an Independent Physicians Association. Journal of Manipulative and Physiological Therapeutics 2001; 24(9): 556-559.

- In this study, 150 chiropractic patients were surveyed.
- Chiropractic care received excellent remarks by percentage, in the following categories:
  - Time to get an appointment – 85%
  - Convenience of office - 58%
  - Access to office by phone - 77%
  - Length of wait - 76%
  - Time spent with provider - 74%
  - Explanation of treatment - 73%
  - Skill of provider - 83%
  - Personal manner of the chiropractor - 92%
  - Overall visit - 83%

CTChiro
Connecticut Chiropractic Association
www.ctchiro.com
2257 Silas Deane Highway | Rocky Hill, CT 06067
(860) 257-0404 | 1-800-966-BACK
www.ctchiro.com

CTChiro
Connecticut Chiropractic Association
www.ctchiro.com

Research Regarding the Cost-Effectiveness and Clinical Outcomes of Chiropractic Care

Summary of Findings

Tracking low back problems ...

The chiropractic group had:

- **lowest prescription medication rates**
- **least costs per episode of low back pain**
- **least guideline-incongruent use of medications and imaging**
- **least likelihood to receive complex medical procedures like surgeries**

$6,983.82
Chiropractic Management
vs.
$28,231.50
Complex Medical Management

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Chiropractic Efficacy Literature Review, Don't just take our word for it! Examine the Research for Yourself ...

1 Spinal manipulation epidemiology: systematic review of cost effectiveness studies.
Michaleff ZA, Lin CW, Maher CG, van Tulder MW. J Electromyogr Kinesiol. 2012;22(5):655-62.

Summary: Spinal manipulation is a cost-effective treatment to manage spinal pain

- Spinal manipulation is a **cost-effective treatment to manage neck and back pain** when used alone or in combination with other techniques compared to GP (general practitioner) care, exercise and physiotherapy

2 Comparison of spinal manipulation methods and usual medical care for acute and subacute low back pain: a randomized clinical trial.

Schneider M, Haas M, Glick R, Stevans J, Landsittel D. Spine (Phila Pa 1976). 2015;40(4):209-17.

Summary: Chiropractic manipulation effective in short term treatment of acute and subacute low back pain

- Chiropractic manual manipulation can **provide greater reductions in self-reported disability and pain compared with usual medical care** for acute and subacute low back pain
- Manual manipulation by a chiropractor should be considered as an effective short term treatment option for patients with acute and subacute low back pain
- Significantly more patients in the manual manipulation group achieved moderate or substantial reductions in disability and pain scores compared to usual medical care

3 Changes in H-reflex and V-waves following spinal manipulation.

Niazi IK, Turker KS, Flavel S, Kinget M, Duehr J, Haavik H. Exp Brain Res. 2015;233(4):1165-73.

Summary: Chiropractic prevents fatigue and increases muscle strength

- Chiropractic adjustments **prevent fatigue and increase muscle strength**
- These results suggest that chiropractic adjustments may be indicated as part of the treatment for the patients who have lost tone of their muscle and/or are recovering from muscle dysfunction such as stroke or orthopedic operations
- These findings will also be of interest to athletes and perhaps the general public

Risk of traumatic injury associated with chiropractic spinal manipulation in Medicare Part B beneficiaries aged 66 to 99 years.

Injury in the chiropractic group was **40** injury incidents per 100,000 subjects

vs.

153 incidents per 100,000 subjects in the primary care group

12

4 Tracking low back problems in a major self-insured workforce: toward improvement in the patient's journey.

Allen H, Wright M, Craig T, Mardekian J, Cheung R, Sanchez R, et al. J Occup Environ Med. 2014;56(6):604-20.

Summary: Lower costs and less drug use in the workplace with chiropractic

The goal of this study was to assess the cost outcomes of treatment approaches to care for back problems in a major self-insured workforce, using published guidelines to focus on low back pain. Three types of care were followed (complex medical management, chiropractic care, physical therapist care).

- The chiropractic group had **the lowest prescription medication rates, least costs per episode of low back pain, and least guideline-incongruent use of medications and imaging**
- The chiropractic group also was the least likely to receive complex medical procedures like surgeries
- **Complex medical management costs were greater than 4 times more expensive** for an episode of low back pain (over 3 years) with neurological findings than chiropractic care ($6,983.82 vs $28,231.5)
- Physical therapy **costs were more than double** per episode of low back pain (over 3 years) with neurological findings compared with chiropractic care ($6,983.82 vs $17,193.92)
- Similar cost savings in favor of chiropractic were found for an episode of low back pain (over 3 years) without neurological findings (chiropractic care = $6,768.43, complex medical management = $29,344.25, physical therapy = $13,448.82)

5 Evidence-based guidelines for the chiropractic treatment of adults with neck pain.

Bryans R, Decina P, Descarreaux M, Duranleau M, Marcoux H, Potter B, Ruegg RP, Shaw L, Watkin R, White E. J Manipulative Physiol Ther. 2014 Jan;37(1):42-63.

Summary: Neck manipulation is recommended in the chiropractic treatment of neck pain

- Studies indicate that **neck manipulation (adjustment), mobilization, manual therapy, exercise, and massage can be recommended** for the chiropractic treatment of nonspecific, mechanical neck pain
- The strongest recommendations are usually made for neck manipulation in combination with another intervention (usually exercise and/or patient education)

6 Patient education with or without manual therapy compared to a control group in patients with osteoarthritis of the hip.

Poulsen E, Hartvigsen J, Christensen HW, Roos EM, Vach W, Overgaard S. A proof-of-principle three-arm parallel group randomized clinical trial. Osteoarthritis Cartilage. 2013 Oct;21(10):1494-503.

Summary: Chiropractic can aid patients with hip osteoarthritis

- For primary care patients with osteoarthritis of the hip, combined treatment of manual therapy provided by a chiropractor and patient education was **more effective than a minimal control intervention**
- Clinical improvements were noted in pain, symptoms and disability for the chiropractic group compared to the group that did home exercises

7 Adding chiropractic manipulative therapy to standard medical care for patients with acute low back pain: results of a pragmatic randomized comparative effectiveness study.

Goertz CM, Long CR, Hondras MA, Petri R, Delgado R, Lawrence DJ, Owens EF, Meeker WC. Spine (Phila Pa 1976). 2013 Apr 15;38(8):627-34.

Summary: Adding chiropractic to standard medical care for back pain offers significant advantages

This study looked at health outcomes of active duty military personnel between the ages of 18 and 35 years of age with acute low back pain of less than 4 weeks duration. Treatments included chiropractic manipulative therapy plus standard medical care or standard medical care alone.

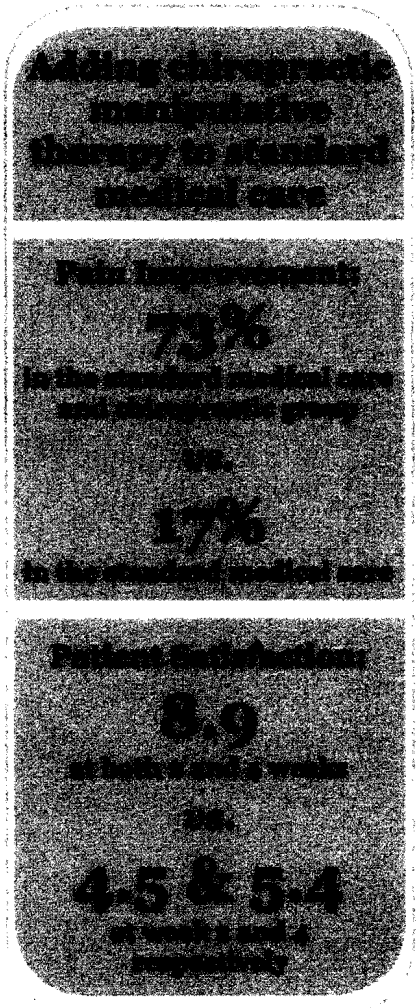
- Results found chiropractic plus standard medical care offers a **significant advantage for decreasing pain intensity, and improving physical function, satisfaction and perceived improvement** in military personnel compared to standard medical care alone
- 73% of participants in the standard medical care and chiropractic group rated their global improvement as pain completely gone, much better, or moderately better, compared with 17% in the standard medical group
- The average satisfaction with care score on a 0 to 10 scale was compared for the chiropractic care and the standard medical care (SMC) groups. The mean score for the chiropractic care group was 8.9 at both weeks 2 and 4; the mean score for the SMC group was 4.5 at week 2 and 5.4 at week 4

8 A randomized controlled trial comparing a multimodal intervention and standard obstetrics care for low back and pelvic pain in pregnancy.

George JW, Skaggs CD, Thompson PA, Nelson DM, Gavard JA, Gross GA. Am J Obstet Gynecol. 2012 Oct 23

Summary: Including chiropractic care with standard obstetric care benefits patients

- Including chiropractic interventions with standard obstetric care for low back and pelvic pain in mid pregnancy **benefits patients more than standard obstetric care alone**
- The benefits of adding chiropractic to standard obstetric care are both subjective and objective
- Chiropractic patients perceived less pain and disability and an overall global improvement in daily activities and their physical examinations revealed improved range of motion, stability, and less irritation at the lumbar and pelvic joints



9 Early predictors of lumbar spine surgery after occupational back injury: results from a prospective study of workers in Washington State.

Keeney BJ, Fulton-Kehoe D, Turner JA, Wickizer TM, Chan KC, Franklin GM. Spine (Phila Pa 1976). 2013;38(11):953-64.

Summary: After back injury workers whose first visit was to a chiropractor had significantly lower odds of surgery

- Workers with an initial visit for the injury to a surgeon had almost nine times the odds of receiving lumbar spine surgery compared to those seeing primary care providers, whereas **workers whose first visit was to a chiropractor had significantly lower odds of surgery**
- About 43% of workers who first saw a surgeon had surgery within 3 years, in contrast to **only 1.5% of those who first saw a chiropractor**

10 Spinal manipulation, medication, or home exercise with advice for acute and subacute neck pain: a randomized trial.

Bronfort G, Evans R, Anderson AV, Svendsen KH, Bracha Y, Grimm RH. Ann Intern Med. 2012 Jan 3;156(1 Pt 1):1-10.

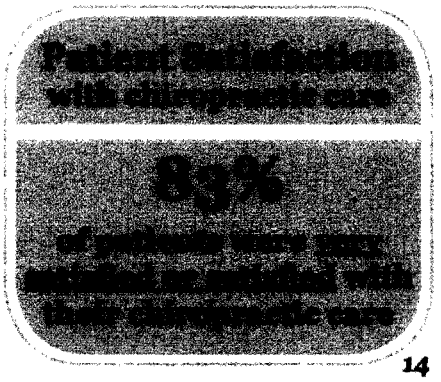
Summary: Chiropractic more effective than medication for adults with acute and subacute neck pain

Adults with current neck pain of 2 to 12 weeks' duration were randomized into 12 weeks of either chiropractic spinal adjustments, medication, or home exercise with advice.

- Chiropractic spinal adjustments and home exercise were **more effective than management with medication in both the short term and long term**
- Patients receiving chiropractic adjustments were **more satisfied with their care than either the home exercise group or the medication group**
- Participants in the medication group reported higher levels of medication use after the intervention

11 Consensus process to develop a best-practice document on the role of chiropractic care in health promotion, disease prevention, and wellness.

Hawk C, Schneider M, Evans MW, Jr., Redwood D. J Manipulative Physiol Ther. 2012;35(7):556-67.



Summary: Approach to wellness care and disease prevention in chiropractic practice

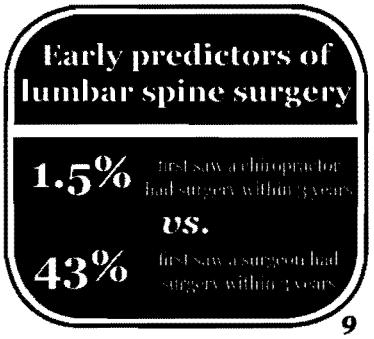
- A best-practice model for chiropractic wellness care emphasizes the following 3 components:
  a) **Manual procedures to promote optimal function and the ability to engage in an active lifestyle**
  b) Screening for risk factors for disease, such as tobacco use, lack of physical activity, and obesity
  c) Evidence-based health behavior counseling to promote health and prevent disease and injury, placing an emphasis on activities and dietary and lifestyle factors that promote optimal function

12 Risk of traumatic injury associated with chiropractic spinal manipulation in Medicare Part B beneficiaries aged 66 to 99 years.

Whedon JM, Mackenzie TA, Phillips RB, Lurie JD. Spine (Phila Pa 1976). 2015;40(4):264-70.

Summary: Seniors have lowered risk of injury following chiropractic visit than medical visit

- Among Medicare beneficiaries aged 66 to 99 years with an office visit for a neuromusculoskeletal problem, risk of injury to the head, neck, or trunk within 7 days was **76% lower** among subjects with a chiropractic office visit than among those who saw a primary care physician
- The cumulative probability of injury in the chiropractic group was 40 injury incidents per 100,000 subjects compared with 153 incidents per 100,000 subjects in the primary care group



13 Value of chiropractic services at an on-site health center.

Krause CA, Kaspin L, Gorman KM, Miller RM. J Occup Environ Med. 2012;54(8):917-21.

Summary: Lower health care use and improved functional status with on-site chiropractic care

- **On-site chiropractic services are associated with lower health care utilization and improved functional status of musculoskeletal conditions**
- Improved functional status indicates potential for reduced indirect costs, including absenteeism, presenteeism and productivity losses, with on-site chiropractic services
- The results of this study support the value of chiropractic services offered at on-site health centers

14 Factors associated with patient satisfaction with chiropractic care: survey and review of the literature.

Gaumer G. J Manipulative Physiol Ther. 2006;29(6):455-62.

Summary: Overall satisfaction among persons ever using chiropractic is very high

- Approximately **83% of patients were very satisfied or satisfied with their chiropractic care**
- Patients find that chiropractic appointments are prompt, waits are not too long, phone access is good and that chiropractors communicate well

15 Immediate effects of spinal manipulative therapy on regional antinociceptive effects in myofascial tissues in healthy young adults.

Srbely JZ, Vernon H, Lee D, Polgar M. J Manipulative Physiol Ther. 2013;36(6):333-41.

Summary: Chiropractic and immediate pain relief

- Spinal manipulation by a chiropractor provided **significant short-term improvements in pressure pain thresholds in young adults**
- The evidence supports further research into the potential benefit and role of chiropractic care in the management of chronic widespread pain syndromes including myofascial pain, and fibromyalgia

CTChiro
Connecticut Chiropractic Association
www.ctchiro.com

2257 Silas Deane Highway | Rocky Hill, CT 06067
(860) 257-0404 | 1-800-966-BACK
www.ctchiro.com

Gmail Senator Hwang <senatorhwang@gmail.com>

Re: You are invited: Outrageous rate hikes forum 7 p.m. tonight at SHU

Lynn Roe <lynn_roe@live.com> Wed, Aug 3, 2016 at 1:38 PM
To: Tony Hwang <tony.hwang@ctsenaterepublicans.com>

Senator Tony Hwang, I can't drive to Hartford, I'm disabled with bone cancer, the main cancer is in my spine. I have Connecticare ins. that costs $ 55 dollars per month, prescription copays are $5 dollars per prescription, doctors are $30 dollars per visit. I receive $1385 dollars per month from SSD, I'm in the red $300-500 dollars per month. I cant afford additional cost.

Get Outlook for Android

[Quoted text hidden]

Gmail Senator Hwang <senatorhwang@gmail.com>

Hwang Web Site Contact

Catherine Jennings <cwj728cat@gmail.com> Mon, Aug 1, 2016 at 1:33 PM
To: tony.hwang@cga.ct.gov

First Name

Catherine

Last Name

Jennings

Email Address

cwj728cat@gmail.com

Phone Number

(203) 452-0745

Mailing Address

425 Judd Road

City

Easton

State

Connecticut

Zip Code

06612

Issue

Other

- Yes, I would like to receive legislative updates from Senator Hwang.

Message

Dear Senator Hwang,
I just wanted to write and ask you to speak out against the double digit health insurance rate hikes. My family has a Connecticare individual policy. We pay roughly $15,000 a year for a family of three. It has been much higher in years past, reaching over $20,000. We do not want to go back to those days. We have picked options to keep our monthly premiums down as much as possible while still having coverage that we can live with. If the insurance companies raise their rates and cherry pick what benefits they offer, the regular person looses out. We are obligated to have health insurance and I feel that the consumer is pretty much at the mercy of the insurance company. Please speak out for the regular people.
Thank you, Catherine Jennings

Gmail Senator Hwang <senatorhwang@gmail.com>

Hwang Web Site Contact

Catherine Jennings <cwj728cat@gmail.com> Mon, Aug 1, 2016 at 1:33 PM
To: tony.hwang@cga.ct.gov

First Name

Catherine

Last Name

Jennings

Email Address

cwj728cat@gmail.com

Phone Number

(203) 452-0745

Mailing Address

425 Judd Road

City

Easton

State

Connecticut

Zip Code

06612

Issue

Other

- Yes, I would like to receive legislative updates from Senator Hwang.

Message

Dear Senator Hwang,
I just wanted to write and ask you to speak out against the double digit health insurance rate hikes. My family has a Connecticare individual policy. We pay roughly $15,000 a year for a family of three. It has been much higher in years past, reaching over $20,000. We do not want to go back to those days. We have picked options to keep our monthly premiums down as much as possible while still having coverage that we can live with. If the insurance companies raise their rates and cherry pick what benefits they offer, the regular person looses out. We are obligated to have health insurance and I feel that the consumer is pretty much at the mercy of the insurance company. Please speak out for the regular people.
Thank you, Catherine Jennings

Gmail **Senator Hwang <senatorhwang@gmail.com>**

insurance rate hikes

Mary Margaret Poster Mon, Aug 1, 2016 at 5:48 PM
<mposter@compassaccountingsolutions.com>
To: Tony.Hwang@cga.ct.gov

Tony,

What can be done to hold these back or somehow lessen these ridiculous hikes?

I think these rate increases are outrageous. I have an individual Connecticare plan, not on the exchange (since those don't really cover anything but catastrophic) and 28% is outrageous. I now pay $569 and that will increase by $159 to $728 for just me. As a self-employed person, I think it's ridiculous that I can't join any sort of 'group' to negotiate a better rate that a company might be offered as a group plan.

I added a comment to the insurance rate board. As a Fairfield resident, thank you for keeping this visible.

Regards,

Mary Margaret Poster

T 203.253.4700

Gmail Senator Hwang <senatorhwang@gmail.com>

Hwang Web Site Contact

tom hannibal <hannibalconstruction@charter.net> Tue, Aug 2, 2016 at 9:29 PM
To: tony.hwang@cga.ct.gov

First Name

tom

Last Name

hannibal

Email Address

hannibalconstruction@charter.net

Phone Number

(203) 268-7198

Mailing Address

30 washington st

City

trumbull

State

Connecticut

Zip Code

06611

Issue

Other

- Yes, I would like to receive legislative updates from Senator Hwang.

Message

Tony
I am writing to you because I cant believe the rate hike ConnectiCare is looking for. As a small business owner in Connecticut I am already taxed to death, paying an outrageous self employment tax, and now this. How can one survive. I started with ConnectiCare in 2013 paying a premium of $789.00 for my self & family, 3 years later I am paying over $1,557.00. WHEN WILL IT STOP ? Another 25-30% and I"ll be over $1,950.00. This proposed amount will be like another mortgage payment for me. I knew when Obamacare was put into place it was going to be the middle class guy, self employed, that would take the brunt of it all, and I was right. How can an Insurance Board Commission let something like this go thru. It's no wonder people are leaving the state in droves to find a place with a cheaper cost of living. I sure hope someone really thinks this thru, and the effects this will have on many small business and individuals.

Thanks in advance for your help

Tom Hannibal

Gmail Senator Hwang <senatorhwang@gmail.com>

Your insurance article was spot-on

Denise Graziano <denise@grazianoassoc.com> Mon, Jul 18, 2016 at 8:45 AM
To: tony.hwang@ctsenaterepublicans.com

Hi Tony,

You are my representative and I have been a constituent since you first ran for office.

Last week I called and "blasted" Connecticare on their absurd, unacceptable request for a 29% increase on our rates. My fiancé and I are SOLO customers, meaning we solicit and purchase our own (very high quality) coverage, NOT from the Exchange. So, when I read your article I was so happy that you said publicly what needs to be said, and apparently for all of us (not just Connecticare customers).

I gave them specific instances of where they are wasting our money, and how ridiculous it is that they are asking for increases in light of those facts. They are actually going to get back to me about a couple of my points. And I did post my comments in the government insurance site. I cannot attend their hearing on a morning in the middle of a work week in Hartford. I also think that for issues this significant, they should have multiple hearings in various counties, not just in Hartford.

I realize that the insurance companies aim high and will get less, but even 15-20% more per month is painful. Thank you for doing all you can to block any actions.

Further, I would like to voice my disgust over the article I saw in the Sunday CT Post regarding Malloy's plan to assess mileage taxes at some point. PLEASE do all you can to prevent any more of his reckless policies and plans. Thank you for your service.

By the way, my parents and I were going to dinner on Sanford street a couple of weeks ago and you were having some sort of event. I don't know if that is an effort to promote more community engagement, but if so, great idea!

Thank you.

Sincerely,

Denise

denise graziano

graziano associates, llc
MARKETING SPECIALISTS
857 Post Road, Ste. 150
Fairfield, CT 06824-6041
PH: 203-254-0195
FX: 203-254-9349
grazianoassoc.com
linkedin.com/in/denisemgraziano
@grazianoassoc

Brand Ambassadorship starts on the INSIDE of your company.
Do you have a plan to build that?

Sales Messaging | Client Retention | Customer Experience
Employee Experience | Trade Show Results

graziano associates
MARKETING SPECIALISTS