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CONNECTICUT PODIATRIC MEDICAL ASSOCIATION ET AL. *v.* HEALTH NET OF CONNECTICUT, INC. (SC 18267)

Norcott, Palmer, Zarella, McLachlan, Harper, Vertefeuille and Bear, Js.*

Argued October 20, 2010—officially released October 18, 2011

Francis J. Brady, with whom were *Michael C. Markowicz* and, on the brief, *Everett E. Newton* and *Marilyn B. Fagelson*, for the appellants (plaintiffs).

Linda L. Morkan, with whom were *Theodore J. Tucci* and *Michael J. Kolosky*, for the appellee (defendant).

J. Gregory Robinson, *Christopher H. Grigorian* and *Kelli Back* filed a brief for the American Podiatric Medical Association as amicus curiae.

Opinion

McLACHLAN, J. The plaintiff podiatrists, Jeffrey F. Yale, Anthony R. Iorio, and R. Daniel Davis (individual podiatrists), and the named plaintiff, the Connecticut Podiatric Medical Association (association), appeal[1] from the grant of summary judgment in favor of the defendant, Health Net of Connecticut, Inc. The plaintiffs argue that the trial court improperly concluded that, as a matter of law, the defendant's practice of reimbursing the individual podiatrists at a lower rate than medical doctors for the same procedures does not constitute "unfair discrimination" in violation of the Connecticut Unfair Insurance Practices Act (CUIPA), General Statutes § 38a-815 et seq., and the Connecticut Unfair Trade Practices Act (CUTPA), General Statutes § 42-110a et seq.[2] The defendant contends that the judgment of the trial court may be affirmed on the alternate ground that the individual podiatrists do not have standing to pursue damages.[3] Because we conclude that the protection against "unfair discrimination" in General Statutes § 38a-816 (10)[4] is limited to denials of reimbursement, we affirm the judgment of the trial court.

The trial court set forth the following relevant facts in its memorandum of decision rendering summary judgment in favor of the defendant. The defendant issues health care insurance policies to provide coverage for medical services and enters into contracts with practitioners of the healing arts to provide those services. The individual podiatrists are licensed to practice in the state of Connecticut and are network providers of services pursuant to provider agreements with the defendant. Pursuant to those agreements, the individual podiatrists administer podiatric care to patients who are members of a health care insurance plan that is issued or administered by the defendant. The defendant has entered into agreements with its insureds to provide health insurance coverage for a variety of medical services, and for each service, the defendant has designated a specific current procedural terminology code (code). In order to receive payment for services that they provide to the defendant's insureds, the individual podiatrists inform the defendant of the type of service provided by using the code that has been assigned to that particular service. Pursuant to its provider agreements with the individual podiatrists, the defendant reimburses them for the services that they have provided by paying a set amount for each code.

The defendant also enters into provider agreements with medical doctors who are licensed to practice in Connecticut. Pursuant to those agreements, the medical doctors are network providers of medical services to patients who participate in a health plan issued or administered by the defendant. Some of the medical doctors administer health care for the foot. Like the individual podiatrists, medical doctors who contract

with the defendant inform the defendant of the services provided by submitting the designated codes. In some instances, the individual podiatrists and medical doctors administer the same services using the same codes, but the defendant pays the medical doctors more than it pays the individual podiatrists for the identical service, designated by the identical code.

The plaintiffs brought the present action, alleging that the defendant's practice of reimbursing the individual podiatrists at a lower rate than medical doctors for the same service, designated by the identical code, constitutes an unfair trade practice in violation of CUTPA and CUIPA. The plaintiffs sought both monetary and injunctive relief. The trial court granted the defendant's motion to dismiss the association's claims for monetary relief, concluding that it lacked representational standing because the claim for monetary damages would require the participation of the individual podiatrists.[5] Subsequently, the court granted the defendant's motion for summary judgment, concluding that § 38a-816 (10) does not require insurance providers to reimburse podiatrists at the same rate that it reimburses medical doctors for the same services. Because the court resolved the issue in favor of the defendant on the merits, it concluded that it was unnecessary to consider the defendant's claim that the individual podiatrists lacked standing. This appeal followed.

Because it implicates subject matter jurisdiction, we first address the defendant's claim that the trial court's judgment may be affirmed on the alternate ground that the individual podiatrists lack standing to pursue damages. The defendant claims that because it reimburses the individual podiatrists' practice groups, any injury suffered by the individual podiatrists is too remote. We disagree.

"[N]otwithstanding the broad language and remedial purpose of CUTPA, we have applied traditional common-law principles of remoteness and proximate causation to determine whether a party has standing to bring an action under CUTPA." *Vacco* v. *Microsoft Corp.*, 260 Conn. 59, 88, 793 A.2d 1048 (2002). "It is axiomatic that a party must have standing to assert a claim in order for the court to have subject matter jurisdiction over the claim. . . . Our standing jurisprudence consistently has embodied the notion that there must be a colorable claim of a direct injury to the plaintiff, in an individual or representative capacity. . . . The requirement of directness between the injuries claimed by the plaintiff and the conduct of the defendant also is expressed, in our standing jurisprudence, by the focus on whether the plaintiff is the proper party to assert the claim at issue. . . . Thus, to state these basic propositions another way, if the injuries claimed by the plaintiff are remote, indirect or derivative with respect to the defendant's conduct, the plaintiff is not the proper

party to assert them and lacks standing to do so. [When], for example, the harms asserted to have been suffered directly by a plaintiff are in reality derivative of injuries to a third party, the injuries are not direct but are indirect, and the plaintiff has no standing to assert them." (Citations omitted.) *Ganim* v. *Smith & Wesson Corp.*, 258 Conn. 313, 346–48, 780 A.2d 98 (2001).

We employ "a three part policy analysis . . . [in applying] the general principle that plaintiffs with indirect injuries lack standing to sue . . . . First, the more indirect an injury is, the more difficult it becomes to determine the amount of [the] plaintiff's damages attributable to the wrongdoing as opposed to other, independent factors. Second, recognizing claims by the indirectly injured would require courts to adopt complicated rules apportioning damages among plaintiffs removed at different levels of injury from the violative acts, in order to avoid the risk of multiple recoveries. Third, struggling with the first two problems is unnecessary [when] there are directly injured parties who can remedy the harm without these attendant problems." (Internal quotation marks omitted.) *Vacco* v. *Microsoft Corp.*, supra, 260 Conn. 89.

The right to reimbursement is derived from the provider agreements. The individual podiatrists, not their practice groups, are the parties to the provider agreements. Because only the individual podiatrists can enforce their contractual rights under the provider agreements, there is no party that is more directly injured or in a better position to remedy the alleged harm. The mere fact that, for the sake of convenience, the practice groups rather than the individual podiatrists directly received the reimbursement that was due pursuant to the provider agreements does not render the injury too remote. Accordingly, the individual podiatrists have standing.

We next address the plaintiffs' claim that the trial court improperly concluded that, as a matter of law, the defendant's practice of reimbursing the individual podiatrists at a lesser rate than medical doctors, for the same procedures, does not constitute "unfair discrimination" in violation of § 38a-816 (10). The plaintiffs contend that the term "unfair discrimination" in § 38a-816 (10), includes setting different reimbursement rates solely on the basis of license. In other words, the plaintiffs argue that the statute prohibits discrimination against podiatrists in favor of medical doctors with respect to the rate of reimbursement. We conclude that the legislature did not intend to include the practice of reimbursing podiatrists and medical doctors at different rates for the same services within the term "unfair discrimination" in § 38a-816 (10). Accordingly, we affirm the trial court's summary judgment in favor of the defendant.

The question of whether the term "unfair discrimina-

tion" in § 38a-816 (10) precludes setting different reimbursement rates solely on the basis of license presents a question of statutory interpretation, over which we exercise plenary review, guided by well established principles regarding legislative intent. See *Hartford/Windsor Healthcare Properties, LLC* v. *Hartford*, 298 Conn. 191, 197–98, 3 A.3d 56 (2010) (explaining plain meaning rule under General Statutes § 1-2z and setting forth process for ascertaining legislative intent).

As directed by § 1-2z, we begin with the text of § 38a-816, which provides in relevant part: "The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance . . . (10) Notwithstanding any provision of any policy of insurance, certificate or service contract, whenever such insurance policy or certificate or service contract provides for reimbursement for any services which may be legally performed by any practitioner of the healing arts licensed to practice in this state, reimbursement under such insurance policy, certificate or service contract shall not be denied because of race, color or creed nor shall any insurer make or permit any unfair discrimination against particular individuals or persons so licensed. . . ."

Subdivision (10) of § 38a-816 may be divided into four clauses. The first clause, "[n]otwithstanding any provision of any policy of insurance, certificate or service contract," prevents private parties from contracting out of the requirements set forth in § 38a-816 (10). The second clause establishes when § 38a-816 (10) applies, namely, "whenever such insurance policy or certificate or service contract provides for reimbursement for any services which may be legally performed by any practitioner of the healing arts licensed to practice in this state . . . ." Because General Statutes § 20-1 defines the "practice of the healing arts" as "the practice of medicine, chiropractic, *podiatry*, natureopathy and, except as used in chapters 384a and 388, the practice of optometry"; (emphasis added); podiatry is included within the term "practice of the healing arts" as used in § 38a-816 (10).

The final two clauses of § 38a-816 (10) define the protection provided by the statute, setting forth the prohibited practices. Whereas the scope of the third clause is easy to discern—it is expressly limited to decisions *denying* reimbursement and its protection extends to denials made on the basis of race, color or creed—the fourth clause simply prohibits insurers from making or permitting "unfair discrimination," without expressly limiting that prohibition to a particular context.[6] Because § 38a-816 (10) applies only when the relevant policy, certificate or contract provides for reimbursement for medical services, at the outset it is clear that the scope of "unfair discrimination" is limited to an insurer's actions with respect to reimbursement.

The two questions we must resolve are: (1) to whom does the protection of the fourth clause extend; and (2) does the prohibition against "unfair discrimination" encompass all aspects of reimbursement, or merely denials of reimbursement. We address each question in turn.

In ascertaining the scope of the fourth clause, we are mindful that "[i]t is a basic tenet of statutory construction that the legislature [does] not intend to enact meaningless provisions. . . . [I]n construing statutes, we presume that there is a purpose behind every sentence, clause, or phrase used in an act and that no part of a statute is superfluous. . . . Because [e]very word and phrase [of a statute] is presumed to have meaning . . . [a statute] must be construed, if possible, such that no clause, sentence or word shall be superfluous, void or insignificant." (Internal quotation marks omitted.) *Lopa* v. *Brinker International, Inc.*, 296 Conn. 426, 433, 994 A.2d 1265 (2010). That rule of statutory construction suggests that in interpreting the scope and meaning of the term "unfair discrimination," in the fourth clause of § 38a-816 (10), we must not render the third clause superfluous. That is, we cannot interpret the fourth clause so broadly that it completely encompasses the meaning of the third clause. The same principle of statutory construction also counsels against interpreting the fourth clause of § 38a-816 (10) in such a way that it is completely included within the meaning of the third clause.

We observe preliminarily that the scope of the third and fourth clauses differs in that the third clause expresses a categorical prohibition—"reimbursement . . . shall not be denied because of race, color or creed"—whereas the prohibition in the fourth clause is conditional. That is, the fourth clause prohibits only discrimination that is "unfair." It follows that "fair" discrimination within the meaning of the fourth clause would be permitted under the statute. Keeping that distinction in mind, we turn to the first question of statutory interpretation before us: to whom does the protection of the fourth clause extend. The fourth clause prohibits insurers from making or permitting "any unfair discrimination against particular individuals or persons so licensed." The key language in identifying the group of persons to whom the protection of the statute extends is "particular individuals or persons so licensed." Two possible interpretations are suggested by the statutory language. First, it is possible to interpret "particular individuals or persons" to signify that the legislature intended to extend protection to single, licensed individuals as individuals, not as members of a particular licensure group. For example, such an interpretation would prohibit reimbursing one particular podiatrist at a different rate than all other licensed podiatrists, indeed, all other licensed practitioners of the healing arts, for providing the same service, not

because he or she is a podiatrist, but for some other reason. Another possible interpretation is that the fourth clause extends protection against discrimination *on the basis of licensure* to particular individuals or persons. Such an interpretation would implicate the factual scenario in the present case, that is, reimbursing podiatrists at a different rate than other licensed practitioners of the healing arts for providing the same service, because they are podiatrists. Because nothing in the statutory language of § 38a-816 (10) resolves the ambiguity, we look to related statutes for guidance as to whether the legislature intended the term "unfair discrimination" to prohibit discrimination against individuals who are licensed or to prohibit discrimination on the basis of licensure itself.

Although "discrimination" is not defined in § 38a-816 (10), the term is used throughout title 38a of the General Statutes, which deals with insurance practices. With respect to health insurance, the insurance commissioner (commissioner) is empowered to prescribe regulations to ensure that rates set for individual health insurance policies "shall not be excessive, inadequate or unfairly discriminatory. . . ." General Statutes § 38a-481 (b). Various health care centers, insurance companies, medical and legal service corporations are required to file a schedule of rates to be paid by subscribers with the commissioner, who may refuse approval of such a schedule if the rates are found "to be excessive, inadequate or discriminatory. . . ." General Statutes §§ 38a-183 (a), 38a-208, 38a-218 and 38a-236. General Statutes § 38a-488 contains a general prohibition against discrimination with respect to health insurance rates and premiums, providing: "Discrimination between individuals of the same class in the amount of premiums or rates charged for any individual health insurance policy, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner, is prohibited." Under General Statutes § 38a-505 (b), "[t]he commissioner shall adopt regulations . . . that specify prohibited policy provisions not otherwise specifically authorized by statute which in the opinion of the commissioner are unjust, unfair or unfairly discriminatory . . . ." As for the health reinsurance association created by General Statutes § 38a-556 (c) (3), "[r]ates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. . . ." The commissioner may refuse approval for a schedule of charges for enrollee coverage for dental services if the commissioner finds the rates to be "unfairly discriminatory." General Statutes § 38a-582 (a).

From these related statutes, it appears that "discrimination" is used in § 38a-816 (10) in a broad manner to mean disparate treatment. Moreover, consistent with General Statutes § 1-1 (a), which directs that in the construction of statutes, "words and phrases shall be

construed according to the commonly approved usage of the language; and technical words and phrases . . . shall be construed and understood accordingly," we construe "unfair discrimination," as used in § 38a-816 (10), to refer generally to "[a] failure to treat all persons equally where no reasonable distinction can be found between those favored and those not favored." Black's Law Dictionary (6th Ed. 1990). That broad definition is consistent with either of the possible interpretations that we have before us. Accordingly, we conclude that the statutory language is ambiguous and turn to extratextual sources for further guidance. Because we also conclude that the statutory language is ambiguous as to the second question presented—namely, whether § 38a-816 (10) was intended to prohibit only discriminatory denials of reimbursement, or whether it also prohibits discriminatory rate setting—we first explain why the statutory text does not resolve that question, then look to the extratextual sources to provide guidance as to both issues.

In addressing the second question of whether the prohibition against "unfair discrimination" applies to all reimbursement decisions, including the setting of reimbursement rates, or is restricted to denials of reimbursement, we first turn to the statutory language of § 38a-816 (10). The fact that the third clause is expressly limited to "denials" of reimbursement at least suggests that the legislature intended the same limitation to apply to the fourth clause. It certainly would be incongruous to extend the protection against other forms of discrimination to reimbursement rates, but to limit the protection against discrimination on the basis of race, color or creed to reimbursement denials. Although that suggestion provides strong evidence, it does not resolve the ambiguity. Accordingly, we look to related statutes. None of the other subdivisions within § 38a-816 prove helpful. Several subdivisions of § 38a-816 prohibit charging an individual a different rate for the same coverage because of various conditions, including "physical disability or mental retardation"; General Statutes § 38a-816 (12); "blindness or partial blindness"; General Statutes § 38a-816 (13); and having been exposed "to diethylstilbestrol through the female parent." General Statutes § 38a-816 (14). None of these subdivisions, refer in any way to whether *reimbursement* at a different rate is prohibited under § 38a-816 (10). Subdivision (15), the only other provision of § 38a-816 that discusses reimbursement, concerns time periods for payment, including reimbursement, but does not address rates of reimbursement.

Other statutes in the insurance chapter of the General Statutes do, however, address discriminatory rate setting. For example, § 38a-236 provides in relevant part: "No nonprofit legal service corporation, as defined in section 38a-230, shall enter into any contract with subscribers unless and until it has filed with the . . .

[c]ommissioner a full schedule of the rates to be paid by the subscriber and has obtained said commissioner's approval thereof. *The commissioner may refuse such approval if he finds such rates are excessive, inadequate or unfairly discriminatory. . . .*" (Emphasis added.) General Statutes § 38a-418 (a), which sets standards for premium rates, expressly provides that such rates "shall not be inadequate, excessive, or unfairly discriminatory." Section 38a-481 (b) establishes procedures for approval of individual health insurance policies and requires the commissioner to adopt regulations to set standards to ensure that the rates set in such policies "shall not be excessive, inadequate or unfairly discriminatory. . . ." See also General Statutes § 38a-582 (commissioner may disapprove schedule of charges for enrollee coverage for dental services if commissioner finds that charges are "excessive, inadequate or unfairly discriminatory"); General Statutes § 38a-623 (prohibiting "unfair discrimination" in setting rates for life insurance premiums); General Statutes § 38a-665 (a) (rates for commercial risk insurance may not be "excessive or inadequate . . . nor shall they be unfairly discriminatory"); General Statutes § 38a-688 (a) (1) (prohibiting "unfairly discriminatory rating practices" for personal risk insurance). The fact that the legislature specifically addressed discriminatory rate setting in these other, similar contexts, yet did not do so in § 38a-816 (10) provides further support, albeit not determinative, for interpreting "unfair discrimination" in the fourth clause of § 38a-816 (10) to be restricted to denials of reimbursement. See *Saunders* v. *Firtel*, 293 Conn. 515, 527, 978 A.2d 487 (2009) ("when a statute, with reference to one subject contains a given provision, the omission of such provision from a similar statute concerning a related subject . . . is significant to show that a different intention existed" [internal quotation marks omitted]).

Because our analysis of the text of § 38a-816 (10) and related statutes does not resolve either of the two questions presented, we turn to extratextual sources. In 1967, the legislature amended § 38a-816, then codified at General Statutes § 38-61, by adding the following antidiscrimination provision: "Notwithstanding any provision of any policy of insurance, certificate or service contract, whenever such insurance policy or certificate or service contract provides for reimbursement for any services *which may be legally performed by* any person licensed under the provisions of chapter 372, reimbursement under such insurance policy, certificate or service contract shall not be denied because of race, color or creed nor shall any insurer make or permit any unfair discrimination against particular individuals or persons licensed under said chapter." (Emphasis added.) Public Acts 1967, No. 852, § 1. The discussion of the amendment, both in the House of Representatives and Senate, clarifies that the legisla-

ture's dual purpose was to benefit both chiropractors, who are licensed pursuant to chapter 372, and their patients by ensuring that individuals who chose to seek treatment from chiropractors would receive insurance coverage. When asked why the amendment was necessary, Representative Paul A. LaRosa explained that, at the time, some health insurance carriers did not reimburse chiropractors for treatment of persons covered under the health insurance policies provided by those carriers. He further explained that because the amendment would require insurance companies to provide coverage for treatment provided by chiropractors, such persons would have the freedom to seek treatment from chiropractors. 12 H.R. Proc., Pt. 8, 1967 Sess., p. 3328; see also 12 S. Proc., Pt. 5, 1967 Sess., p. 2346, remarks of Senator John P. Janovic ("This act will prohibit an insurance company from denying benefits to a person treated by a chiropractor. It will prohibit insurance companies from discriminating against a chiropractor for services rendered under future insurance contracts.").

In 1969, the legislature replaced the phrase "person licensed under the provisions of chapter 372" with the phrase "practitioner of the healing arts licensed to practice in this state." Public Acts 1969, No. 651, § 1. At that time, § 20-1 defined the "practice of the healing arts" as the practice of medicine, chiropractic, naturopathy and osteopathy. The purpose of the 1969 amendment was to extend the antidiscrimination protection to naturopathic and osteopathic physicians. See 13 S. Proc., Pt. 6, 1969 Sess., pp. 3039–40, remarks of Senator George L. Gunther. Senator Gunther described the scope of the protection afforded to practitioners of the healing arts by the amendment, which is now codified at § 38a-816 (10), as eliminating "any insurance reimbursement being *denied* anyone based on race, color, creed, *or healing art*." (Emphasis added.) Conn. Joint Standing Committee Hearings, Insurance, 1969 Sess., p. 1. In 1981, the legislature amended § 20-1 to include podiatry among the healing arts—thus extending the protection against "unfair discrimination" in § 38a-816 (10) to podiatrists. Public Acts 1981, No. 81-471, § 4.

The legislative history supports two conclusions regarding the scope of the protection against "unfair discrimination" provided by § 38a-816 (10). First, the legislative history supports our conclusion that the fourth clause of § 38a-816 (10) was intended to prevent "unfair discrimination" based on licensure. That conclusion is supported both by the gradual and deliberate extension of the protection to different licensures and by Senator Gunther's remark that § 38a-816 (10) protected against discrimination based on the particular "healing art." The legislative history also suggests, however, that the type of decisions contemplated by § 38a-816 (10) were limited to *denials* of reimbursement. That conclusion is supported by the dual purpose of § 38a-816 (10), which not only protects practitioners of the

healing arts from discrimination, but also ensures that subscribers will have coverage for treatment by any practitioner of the healing arts licensed to practice in this state, regardless of the particular license that practitioner holds. The second purpose would be directly implicated only by denials of reimbursement, not by reimbursement at different rates.[7] Second, all of the remarks during the legislature's consideration of the original bill in 1967 and its amendment in 1969, refer to *denials* of reimbursement. See Public Acts 1967, No. 852, § 1; Public Acts 1969, No. 651, § 1. The entire thrust of the legislative changes to the statute was merely to include additional categories of practitioners of the healing arts for whom reimbursement is required. Not one remark indicates that the legislature intended to prohibit insurers from reimbursing practitioners at different rates based on license. Indeed, none of the remarks even mentions rates of reimbursement. Had the legislature intended such a result, it seems likely that someone associated with the insurance industry would have expressed an opinion on the matter in committee hearings. Indeed, there was opposition to the original proposed version of the statute, but not on the subject of pay parity. See Conn. Joint Standing Committee Hearings, Insurance, 1967 Sess., pp. 170–72, remarks of Joseph Cooney for Connecticut State Medical Society. Accordingly, we conclude that § 38a-816 (10), by prohibiting "unfair discrimination," bars the denial of reimbursement on the basis of the particular license held by a practitioner of the healing arts,[8] but does not preclude setting different reimbursement rates on the basis of the particular license held by a practitioner of the healing arts.

The judgment is affirmed.

In this opinion NORCOTT, ZARELLA, HARPER, VERTEFEUILLE and BEAR, Js., concurred.

* This case originally was argued before a panel of this court consisting of Justices Norcott, Palmer, McLachlan and Vertefeuille, and Judge Bear. Thereafter, on July 22, 2011, the court, pursuant to Practice Book § 70-7 (b), sua sponte, ordered that the case be considered en banc. Accordingly, Justices Zarella and Harper were added to the panel, and they have read the record, briefs and transcript of the oral argument.

[1] The plaintiffs appealed from the decision of the trial court to the Appellate Court and we transferred the appeal to this court pursuant to General Statutes § 51-199 (c) and Practice Book § 65-1.

[2] The plaintiffs also contend that the trial court abused its discretion in denying their motion to strike or to respond to the defendant's argument, raised for the first time in its reply brief in support of its motion for summary judgment, that nondiscriminatory "market forces" justify the defendant's conduct. Because the trial court did not render summary judgment on the basis of "market forces," and because we do not affirm the trial court's judgment on that basis, we do not address that claim.

[3] Although the defendant's preliminary statement of the issues raised as an alternate ground for affirmance the claim that the action was federally preempted, the defendant expressly abandoned that argument in its brief.

[4] General Statutes § 38a-816 provides in relevant part: "The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance . . .

"(10) Notwithstanding any provision of any policy of insurance, certificate or service contract, whenever such insurance policy or certificate or service contract provides for reimbursement for any services which may be legally

performed by any practitioner of the healing arts licensed to practice in this state, reimbursement under such insurance policy, certificate or service contract shall not be denied because of race, color or creed nor shall any insurer make or permit any unfair discrimination against particular individuals or persons so licensed. . . ."

[5] Because the association's claims for injunctive relief were not the subject of the motion to dismiss, the association remains a plaintiff in this action.

[6] The dissent asserts that our reading of the statutory language, which construes the express limitation of the third clause to denials of reimbursement to mean what it says, that is, to limit the scope of the third clause to *denials* of reimbursement, is "simply . . . inconceivable . . . ." The dissent contends that the literal language of § 38a-816 (10), so construed, permits discrimination on the basis of race, color or creed in setting reimbursement rates. Section 38a-816 (10) does not, however, sanction *any* discriminatory actions; it provides a civil remedy for discriminatory denials of reimbursement.

As explained in this opinion, the text and legislative history of this statute reflect that the legislature had a particular issue in mind in drafting this legislation—namely, preventing discriminatory denials of reimbursement, in the interest of both practitioners of the healing arts and patients, who have a right to have broad access to health care. All of the evidence supports our conclusion that the legislature crafted the statute to address that specific issue.

In addition, the issue of discrimination on the basis of race, color or creed is not before us in this appeal. The present case does not involve such a claim, and none of the parties nor the amici have briefed this issue. We acknowledge, however, that our decision could be relied upon as authority for the proposition that § 38a-816 (10) provides no remedy for discrimination on the basis of race, color or creed. It is difficult to imagine that the legislature would not intend to provide a remedy for such discrimination. It is worth noting, however, that the genealogy of the statute reflects that the legislature's provision of remedies for race discrimination have been incremental from the outset. When the discrimination provision originally was enacted; see Public Acts 1967, No. 852, § 1; race discrimination was deemed an unfair practice only when an insurance policy covered procedures that a licensed chiropractor could perform. It also is worth noting that the only comment in the legislative history regarding the clause barring race discrimination in denials of reimbursement is from William Cotter, the insurance commissioner at that time, who testified at a committee hearing on the original bill as follows: "As far as discrimination because of race, color or creed, we have exerci[s]ed authority over this for [some time and] this is not a problem as we see it." Conn. Joint Standing Committee Hearings, Insurance, 1967 Sess., p. 173.

We believe that the proper approach, rather than inferring that the only options are to rewrite the statute or to leave certain discrimination without a remedy, is to recognize that the legislature simply did not anticipate the problem, and to give the legislature the opportunity to address it.

Accordingly, we will not overreach to decide an issue that is not before us. Judicial restraint counsels us to commend the issue to the attention of the legislature for further review, as is appropriate. We consistently have held that "the task of changing the law lies with the legislature, and not with the judiciary. In construing a statute, the cardinal principle of construction is to ascertain the intent of the legislature. If an act passed by the legislature is within its constitutional power, it is not the business of the court to attempt to twist the interpretation of the law to conform to the ideas of the judges as to what the law ought to be or to attempt to make the law coincide with their ideas of social justice. The judicial function should not invade the province of the legislature." (Internal quotation marks omitted.) *Director of Health Affairs Policy Planning* v. *Freedom of Information Commission*, 293 Conn. 164, 182, 977 A.2d 148 (2009).

[7] The plaintiffs contend that reimbursement at different levels *could* implicate coverage. By way of illustration, the plaintiffs offer a hypothetical example of a podiatrist being reimbursed $1 for the same service for which a medical doctor is reimbursed $100. Nothing in the record substantiates the likelihood of such an extreme discrepancy in reimbursement rates. Indeed, such a discrepancy would require insurers to act against their own best interest by in effect discouraging lower cost providers from participating in the insurance network, which would force subscribers to seek treatment with the higher cost providers. At a time when society is concerned with the high costs of health care in general, it would make no sense to adopt

rules that would discourage the lowest cost provider from performing the required treatment. Moreover, if an insurer were to act in such a manner, we express no opinion as to whether such an action could be deemed tantamount to a denial and a bad faith act to make an end run around the law.

[8] The plaintiffs claim that other states and federal statutes require that doctors of podiatric medicine and medical doctors be paid equally for administering the same services. They contend that these statutes support their claim that § 38a-816 (10) requires pay parity. We confine our analysis to our state statutes and applicable precedent.