

REGULAR CALENDAR

October 24, 2022

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on Commerce and Consumer Affairs to which was referred HB 1245-FN,

AN ACT relative to copayments for services rendered by a chiropractor. Having considered the same, report the same: **NOT RECOMMENDED FOR FUTURE LEGISLATION.**

Rep. Christy Bartlett

FOR THE COMMITTEE

COMMITTEE REPORT

Committee:	Commerce and Consumer Affairs
Bill Number:	HB 1245-FN
Title:	relative to copayments for services rendered by a chiropractor.
Date:	October 24, 2022
Consent Calendar:	REGULAR
Recommendation:	NOT RECOMMENDED FOR FUTURE LEGISLATION

STATEMENT OF INTENT

More payments by insurance companies will increase premiums. The committee understands that some rely on chiropractic care, but few see primary care physicians as often as chiropractors and this is considered a specialty by insurance companies that provide the coverage.

Vote 17-0.

Rep. Christy Bartlett
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Commerce and Consumer Affairs

HB 1245-FN, relative to copayments for services rendered by a chiropractor. **NOT RECOMMENDED FOR FUTURE LEGISLATION** .

Rep. Christy Bartlett for Commerce and Consumer Affairs. More payments by insurance companies will increase premiums. The committee understands that some rely on chiropractic care, but few see primary care physicians as often as chiropractors and this is considered a specialty by insurance companies that provide the coverage. **Vote 17-0.**

Original: House Clerk
Cc: Committee Bill File

Commerce Committee 2022 Interim Study

HB1582-repealing the granite state paid family leave plan – **Not recommended for future legislation** Dpty Commissioners Bettencourt & Lavers testified- Met Life has offered a proposal and submitted rates approved to become effective 1-1-23-The Departments want the voluntary program to move forward- it will run for 5 yrs with an option to request an add'l 2 yrs after that period. Vote: 17-0

SB287 relative to balance billing for certain healthcare services- **Not recommended for future legislation**- NHID Michelle Eagan said the national “no surprises” act has been put into NH law- dispute resolution issues have been adjusted as required by the court action by feds- NH Ins Dept would prefer to handle the disputes. Vote 17-0

SB121-relative to a state-based health exchange- **Not recommended for future legislation** there are many issues that this bill does not/cannot address/perhaps a study committee could address some of them/NHID would administer Vote 17-0

HB1245-relative to copayments for services rendered by a chiropractor/ **Not recommended for future legislation**/more payments by insurance companies will increase premiums/understood that some rely on chiropractic, but few see primary care physicians as often as chiropractors and this is considered a specialty by insurance companies that provide the coverage. Vote 17-0

HB488-establishing a committee to study the benefits of allowing NH citizens to purchase health insurance from out-of-state companies **Not recommended for future legislation**/ this committee continues to believe that consumers are better-served by purchasing insurance from companies licensed and regulated by the NHID/if under consumer protection statutes, companies subject to triple damages and these cos don't want to enter the state under those statutes Vote 16-1

HB1028-relative to the form of individual health insurance policies- **Not recommended for future legislation**/ this applies to individual policies with abbreviated coverage/they are only available for short periods and cannot meet the federal requirements of the Affordable Care Act and remain profitable Vote 16-1

HB1019-establishing a committee to study the replacement of certain professional licenses with mandatory minimum liability insurance requirements/**Not recommended for future legislation** an insurance policy does not take the place of licensing requirements enforced by the state/the state offers licensing for many professions and if the licensee doesn't meet those requirements, the state and cancel the license/ if enacted, insurance companies are not required to write a policy for any profession/the company can deny or cancel coverage/if the insurance company also had to determine whether an applicant met certain minimum standards, the premiums would be much higher, if available at all. General Liability policies are only available to cover negligence and minimum limits may not be adequate to make a claimant whole after a claim. Vote 16-1

Rep Christy D Bartlett 10/19/22

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on HB 1245-FN

BILL TITLE: relative to copayments for services rendered by a chiropractor.

DATE: October 19, 2022

LOB ROOM: 302 - 304

MOTION:

Interim Study (2nd yr) Not Recommended for Future Legislation

Moved by Rep. Bartlett

Seconded by Rep. Hunt

Vote: 17-0

Respectfully submitted,

Rep Keith Ammon, Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on HB 1245-FN

BILL TITLE:

DATE: 10/19/20

LOB ROOM: 302 - 304

MOTION:

Recommended for Future Legislation

Not Recommended for Future Legislation

Moved by Rep. Bartlett Seconded by Rep. Hunt Vote: 17-0

Respectfully submitted,

Rep. Keith Cunniff
Committee Clerk



STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

10/17/2022 12:32:27 PM
Roll Call Committee Registers
Report

2022 SESSION

Commerce and Consumer Affairs

Bill #: HB 1245 Motion: NR *Bartlett* AM #: _____ Exec Session Date: 10/19/22

Members	YEAS	Nays	NV
Hunt, John B. Chairman	17		
Potucek, John M. Vice Chairman	1		
Osborne, Jason M. <i>B</i>	2		
Ammon, Keith M. Clerk	3		
Abramson, Max	4		
Ham, Bonnie D.	5		
Depalma IV, Joseph <i>D</i>	6		
Greeson, Jeffrey <i>M</i>	7		
Johnson, Dawn M.	8		
Terry, Paul A.	9		
Bartlett, Christy D.	10		
Abel, Richard M.			
Herbert, Christopher J.	11		
Van Houten, Constance	12		
Fargo, Kristina M.			
Weston, Joyce	13		
Beaulieu, Jane E.	14		
Burroughs, Anita D.	15		
McAleer, Chris R.	16		
TOTAL VOTE:	17	<i>0</i>	

SUBCOMMITTEE WORK SESSION on HB 1245-FN

BILL TITLE: relative to copayments for services rendered by a chiropractor.

DATE: 10/13/22

Subcommittee Members: Reps. Hunt, Potucek, Ammon, Osborne, Abramson, Ham, Depalma IV, Greeson, Johnson, Terry, Bartlett, Abel, Herbert, Van Houten, Fargo, Weston, Beaulieu, Burroughs and McAleer

Comments and Recommendations:

- MOTION:** Recommended for Future Legislation
 Not Recommended for Future Legislation

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

Respectfully submitted,

Rep. _____
Subcommittee Chairman/Clerk

CONSENT CALENDAR

March 7, 2022

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on Commerce and Consumer Affairs to which was referred HB 1245-FN,

AN ACT relative to copayments for services rendered by a chiropractor. Having considered the same, report the same with the recommendation that the bill be

REFERRED FOR INTERIM STUDY.

Rep. Dawn Johnson

FOR THE COMMITTEE

CONSENT CALENDAR

Commerce and Consumer Affairs

HB 1245-FN, relative to copayments for services rendered by a chiropractor. **REFER FOR INTERIM STUDY.**

Rep. Dawn Johnson for Commerce and Consumer Affairs. Given the uniqueness of chiropractors' practice, the Commerce and Consumer Affairs committee decided that to resolve the issue of co-pays, the committee would need more time. **Vote 18-0.**

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on HB 1245-FN

BILL TITLE: relative to copayments for services rendered by a chiropractor.

DATE: March 3, 2022

LOB ROOM: 302-304

MOTIONS: REFER FOR INTERIM STUDY

Moved by Rep. Johnson

Seconded by Rep. Terry

Vote: 18-0

CONSENT CALENDAR: YES

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep Keith Ammon, Clerk

2022 SESSION

Commerce and Consumer Affairs

Bill #: HB1245 Motion: IS AM #: _____ Exec Session Date: 3/3/22

<u>Members</u>	<u>YEAS</u>	<u>Nays</u>	<u>NV</u>
Hunt, John B. Chairman	18		
Potucek, John M. Vice Chairman	1		
Osborne, Jason M.	2		
Ammon, Keith M. Clerk	3		
Abramson, Max	4		
Ham, Bonnie D.	5		
Depalma IV, Joseph <i>Acton</i>	6		
Greeson, Jeffrey	7		
Johnson, Dawn M.	8		
Terry, Paul A.	9		
Bartlett, Christy D.	10		
Abel, Richard M.	11		
Herbert, Christopher J. →			
Van Houten, Constance	12		
Fargo, Kristina M.	13		
Weston, Joyce	14		
Beaulieu, Jane E. <i>Tanner</i>	15		
Burroughs, Anita D.	16		
McAleer, Chris R.	17		
TOTAL VOTE:	18	0	

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 1245-FN

BILL TITLE: relative to copayments for services rendered by a chiropractor.

DATE: March 15, 2022

Subcommittee Members: Reps. Hunt, Potucek, Ammon, Terry, Greeson, Bartlett and Weston

Comments and Recommendations:

MOTIONS: REFER FOR INTERIM STUDY

Moved by Rep. Rep. Bartlett

Seconded by Rep. Rep. Terry

Vote: 6-0

Respectfully submitted,

Rep. Keith Ammon
Subcommittee Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 1245-FN

BILL TITLE: relative to copayments for services rendered by a chiropractor.

DATE: February 10, 2022

Subcommittee Members: Reps. Hunt, Bartlett, Greeson, Terry, Burroughs and Ammon

Comments and Recommendations: Discussed specialist vs PC and the difference of co-pay vs utilization

Respectfully submitted,

Rep. John Hunt
Subcommittee Chairman

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 1245-FN

BILL TITLE: relative to copayments for services rendered by a chiropractor.

DATE: 2/10/22

Subcommittee Members: Reps. Hunt, Bartlett, Greeson, Terry, Burroughs and Ammon

Comments and Recommendations:

Discussed specialist vs PC
and the dilemma of copay vs
utilization

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

Respectfully submitted,

Rep. [Signature]
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

PUBLIC HEARING ON HB 1245-FN

BILL TITLE: relative to copayments for services rendered by a chiropractor.

DATE: February 2, 2022

LOB ROOM: 302-304

Time Public Hearing Called to Order: 11:40 a.m.

Time Adjourned: 12:10 p.m.

Committee Members: Reps. Hunt, Potucek, Ammon, Ham, Greeson, Johnson, Terry, Bartlett, Abel, Herbert, Van Houten, Fargo, Weston, Beaulieu, Burroughs and McAleer

Bill Sponsors:

Rep. Lundgren

Rep. Dolan

Rep. Love

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep David Lundgren

Thank you Mr. Chair and committee for allowing us to talk on HB1245. I'll be very brief because I know what it's like to be sitting there for hours on end. Basically this bill has to do with reduction of copays. Costs due to avoiding any oil opioids this bill will be no increase to insurance costs and I just have a couple other things: 90% of the literature that I've seen showed cost savings which improve patient satisfaction, lower opioid use among patients with first line access to chiropractors. Chiropractors and non specialist, we'd like to be taken out of that category to make it allowable for us to reduce our Co pays. Our co-pays right now run from \$40 to \$60, a PCP runs from say \$10 to \$20. It makes it the access to our care that much easier. I would be happy to try to answer any questions.

Rep Bartlett

Q: Are you a chiropractor?

A: Yes I am. I've been a chiropractor for 45 years.

Rep Burroughs

Q: Has the legislature been responsible for setting copay rates?

Hunt: Yes copays and deductibles. The only chiropractor bill I recall is if they covered it they would have to cover 12 visits. We passed that legislation carriers stopped covering it.

Rep Bartlett

Q: Are there carriers that would not cover chiropractic?

A: I haven't had any. Teachers copays are \$5. State employees \$10. The general public could be 40-50.

Mark Stagnone

- I am a Chiropractor in Londondeerry
- Trying to address Co-pays for about 17 years now.
- Chiropractors are billed co-pays of \$50-60 when specialists see \$40
- Patient carries the burden of payment and quits coming
- State and Municipal workers don't pay as much
- Policies exist that are not affected by this classification
- Opioid epidemic could be less

Rep Beaulieu

Q: Are chiropractors considered like a naturopath?

A: We are a primal portal of entry health care providers. We are accessible directly without a referral. We addressed the gatekeeper years ago. Mr. Chairman was helpful addressing that issue. We're constantly fighting strategies meant to restrict our ability. They limit number of visits and amounts. This part throws the financial responsibility on the patient.

Rep Johnson

Q: Would you believe I have an insurance policy that gives me unlimited chiropractic and my copays are low?

Rep Hunt: It's more affordable than going to a surgeon. Which companies are doing it? I'm worried this legislation can only affect small group health insurers.

A: Anthem was the initiator of this strategy. The first hearing we had on this was actually over in the Senate Commerce Committee, and at the time the chairman didn't want to mandate this. He thought that the marketplace might be able to help manage this problem. It hasn't but I will never forget in that hearing the chairman pointed at the representative from anthem and he said this isn't right you need to fix it and that's pretty much how the hearing ended and we were optimistic. But nothing ever happened. There was a point in time in April of 2011 in our interactions with Paul Rodgers from Anthem where in her communication to with Mr. James Monahan who was our lobbyist at the time, where they actually indicated to us that they couldn't change this designation because their computer systems there were a multistate and they couldn't assure us that with any time element or anything of that nature that they would be able to fix this anytime soon that it was a computer system issue. And so once again we were left kind of you know kicking the can down the road. This is why we keep coming back on this issue, it hasn't gone away, in fact what has happened is that there have been other insurance companies that have probably noticed the effectiveness of this strategy and we have started to see these specialist copays creep up in some other policies.

Rep McAleer

Q: IF this passes, could insurance companies do a backdoor thing to offset it?

A: I'm sure there's something that could take place. I don't know the possibilities. I'm hoping there isn't some punitive result from me being here testifying. There are thousands of these policies out there that are working very well for them. I mean we don't hear from the police or fire or teachers where they're saying oh Gee the chiropractors are running us broke. You know in fact the studies that are out that demonstrate that as you increase chiropractic utilization you reduce costs on the medical side of that equation. There are so many studies that we have submitted on this over the years where other Anthems _ Tennessee anthem in 2010, I think it was witnessed millions of dollars of savings when they increase their access to chiropractic. We're not trying to burden the insurance

companies with this, we really think and we truly believe that if they actually used us more that there they would see cost savings. We would see beneficial results in the opioid crisis. So many studies that are coming out of Dartmouth on this and I'm happy to share these studies with you in whatever fashion you would ever want me to.

Dr. Ken Gabriel, NH Chiropractic Assoc

- I have lost family members to opioid addiction
- Support the bill
- Adresses chronic pain
- If you call a chiropractor you are 47.2% less likely to have surgery
- Chiropractic care and medical care and alternative care are better than medical care alone
- Many studies are supporting

P

Rep Greeson

Q: line at first line add defense do you experience the access issues that we have heard about especially with mental health care because they require a referral and there may not be enough providers in the network taking new patients since you are a first line of defense where they could call you directly is there an issue with lack of access and then just on top of that we are you aware of the the multibillion dollar settlement against johnson and johnson just this week for involvement in the open

A: I'm not aware of Johnson and Johnson. There are 400 licensed chiropractors in NH. Great state to live in. We're adding licensing every year. Positive sign for our profession and our state in terms of access.

Michelle Heaton, Insurance Dept

- Legal counsel for the Insurance Department
- Do not take a position on this
- Studies done in 2014 and 2017 are inconsistent with other studies
- Increased cost sharing for primary care services
- After risk adjustment an increase in spending on chiropractic services is associated with an increase in total spending when considering all the conditions which chiropractic care is used.
- Those two reports are available on the insurance department website if you want to read

House Remote Testify

Commerce and Consumer Affairs Committee Testify List for Bill HB1245 on 2022-02-02

Support: 59 Oppose: 0 Neutral: 0 Total to Testify: 0

[Export to Excel](#)

<u>Name</u>	<u>City, State</u> <u>Email Address</u>	<u>Title</u>	<u>Representing</u>	<u>Position</u>	<u>Testifying</u>	<u>Non-Germane</u>	<u>Signed Up</u>
McCann, Brendan	Newmarket, NH bhmccann@gmail.com	A Member of the Public	Myself	Support	No	No	1/28/2022 10:29 AM
gabriel, kenneth	salem, NH jig25@aol.com	A Member of the Public	Myself	Support	No	No	1/28/2022 11:11 AM
maroon, Stephen	Kingston, NH Smaroonchiro@gmail.com	A Member of the Public	Myself	Support	No	No	1/28/2022 11:12 AM
Couto, karen	Derry, NH klcouth123@gmail.com	A Member of the Public	Myself	Support	No	No	1/28/2022 11:15 AM
digregorio, karen	manchester, NH ksdigregorio@gmail.com	A Member of the Public	Myself	Support	No	No	1/28/2022 11:23 AM
powell, bernard	Londonderry, NH qwangae@gmail.com	A Member of the Public	Myself	Support	No	No	1/28/2022 11:23 AM
Gabriel, Kenneth E	Salem, NH Kensrumpire@aol.com	A Member of the Public	Myself	Support	No	No	1/28/2022 11:24 AM
abo elsaad, Dawn	Salem, NH dgabr1234@aol.com	A Member of the Public	Myself	Support	No	No	1/28/2022 11:25 AM
priore, frank	Salem, NH fjpriore@comcast.net	A Member of the Public	Myself	Support	No	No	1/28/2022 11:27 AM
Morgano Sr., Richard	Salem, NH Rick1msr@gmail.com	A Member of the Public	Myself	Support	No	No	1/28/2022 12:13 PM
Lufkin, Kirk	Kensington, NH dr.klufkin@gmail.com	A Member of the Public	Myself	Support	No	No	1/28/2022 12:21 PM
Narducci, janice	merrimack, NH Narducci4@comcast.net	A Member of the Public	Myself	Support	No	No	1/28/2022 12:26 PM
powell, shaun	Londonderry, NH handofblood37@gmail.com	A Member of the Public	Myself	Support	No	No	1/28/2022 12:27 PM

Marcoux, Joseph	Northfield, NH Joeymarcoux@yahoo.com	A Member of the Public	Myself	Support	No	No	1/30/2022 8:35 PM
Marcoux, Sarah	Northfield, NH marcouxhouse@yahoo.com	A Member of the Public	Myself	Support	No	No	1/30/2022 8:35 PM
Congdon, Deborah	Kensington, NH D.congdon@comcast.net	A Member of the Public	Myself	Support	No	No	1/30/2022 9:21 PM
Guerriere, Diane	Tuftonboro, NH drdiane@wolfechiro.net	A Member of the Public	Myself	Support	No	No	1/31/2022 7:34 AM
Swiesz, Matthew	Durham, NH drswiesz@gmail.com	A Member of the Public	The New Hampshire State Chiropractic Society	Support	No	No	1/31/2022 7:53 AM
Lamson, Tyler	Seabrook, NH spinedoc20@gmail.com	A Member of the Public	Seabrook Chiropractic & Rehabilitation Center	Support	No	No	1/31/2022 8:58 AM
Celeste, Robert	Manchester, NH rccceleste3@gmail.com	A Member of the Public	Myself	Support	No	No	1/31/2022 3:19 PM
Manfrate, Tonya	Manchester, NH tonyamanfrate-ama@gsinet.net	A Member of the Public	My self	Support	No	No	1/31/2022 3:20 PM
Petrusewicz, Carol	Rochester, NH clmcc2befree@yahoo.com	A Member of the Public	Myself	Support	No	No	1/31/2022 3:31 PM
Krikorian, Steven	Windham, NH skrikorian@bizanalytica.com	A Member of the Public	Myself	Support	No	No	1/31/2022 5:04 PM
Sica, Doreen	Londonderry, NH Crystalreflect@aol.com	A Member of the Public	Myself	Support	No	No	1/31/2022 6:15 PM
Sica, Michael	Londonderry, NH Pupasica@aol.com	A Member of the Public	Myself	Support	No	No	1/31/2022 6:27 PM
Holtshouser, Stuart	Manchester, NH stuholtshouser@gmail.com	A Member of the Public	Myself	Support	No	No	2/1/2022 6:25 AM
Deuso, Jayme	Wolfeboro, NH jayme@wolfechiro.net	A Member of the Public	Myself	Support	No	No	2/1/2022 7:20 AM
Berthiaume, Ken	Manchester, NH keneb2@yahoo.com	A Member of the Public	Myself	Support	No	No	2/1/2022 11:00 AM
lovetere, john	greenland, NH drdukelove@hotmail.com	A Member of the Public	Myself	Support	No	No	2/1/2022 11:17 AM
Sutin, Patricia	Litchfield, NH Patsutin@gmail.com	A Member of the Public	Myself	Support	No	No	2/1/2022 1:28 PM
Sutin, Michael	Litchfield, NH Msutin2@gmail.com	A Member of the Public	Myself	Support	No	No	2/1/2022 1:29 PM

Archived: Tuesday, April 5, 2022 2:37:44 PM
From: mhstagnone@comcast.net
Sent: Sunday, February 20, 2022 7:01:53 PM
To: ~House Commerce Committee
Subject: HB1245finalcomments
Importance: Normal

Dear Representative,

It has come to my attention that the Committee is likely to vote on HB1245 this week. Representative Lundgren has shared with me a couple concerns expressed to him via Chairman Hunt. Please allow me to address these concerns.

Chairman Hunt has indicated some level of satisfaction relative to the 12 visit minimum required by New Hampshire law for chiropractic services. He brought this up in conversation with me following my testimony on February 2nd as well. This legislation was passed approximately 15-20 years ago in relation to the medical gatekeeper referral requirement some insurance companies were placing on chiropractic benefits. It was yet another highly effective strategy at limiting the patient's ability to access their chiropractic benefits. As part of the agreement to remove this requirement the 12 visit minimum, modeled after Medicare benefits at the time, was adopted. As some of you may have already calculated, it does not matter what number of visits a patient is allowed if the "specialist" co payment requires they cover the entirety of their care. Some of these "specialist" policies come into our offices with "unlimited" visits. It doesn't matter, the patient experiences no benefit.

Additionally is a concern that other providers, specifically Physical Therapists, will want to jump on board this legislation. Approximately four or five years ago the New Hampshire Chiropractic Association actually pursued similar legislation in conjunction with the Physical Therapists. We learned several things as a result of that experience. First, billing and compensation for the two professions is handled quite differently. P.T.'s are allowed the use of a much broader number of treatment codes in a cumulative fashion enabling a single session to easily exceed \$100 and more. Chiropractors are not extended the same benefit whereas we are limited to manipulation only by most insurers. This likely accounts for the findings of the Compass Study commissioned by the State of New Hampshire at the time which found that while Chiropractic services reduced overall expense, P.T. utilization actually resulted in increased costs. The Compass Study also found that while opioid use declined when Chiropractic was included, opioid utilization was more likely with Physical Therapy. It has recently come to our attention that numerous Veterans Hospitals are now encouraging the Chiropractor as the initial patient contact for these and other reasons. The citizens of our state deserve similar access to their benefits.

Thank you again for your consideration,

Mark W. Stagnone, D.C.
Immediate Past President, New Hampshire Chiropractic Association
50 Nashua Rd. STE 106
Londonderry, NH 03053
603.434.1236

Archived: Thursday, May 19, 2022 12:44:40 PM
From: Aidan Ankarberg
Sent: Wednesday, February 2, 2022 5:29:58 PM
To: ~House Commerce Committee
Subject: Fwd: NHCA Letter Re: HB1245
Importance: Normal

Get Outlook for iOS

From: Kirk Lufkin <dr.klufkin@gmail.com>
Sent: Wednesday, February 2, 2022 5:05:31 PM
To: Aidan Ankarberg <Aidan.Ankarberg@leg.state.nh.us>
Subject: NHCA Letter Re: HB1245

Rep. Ankarberg,

Attached is a letter from the New Hampshire Chiropractic Association addressed to Rep. Hunt, regarding House Bill 1245. We greatly appreciate your help in forwarding it to him.

Yours in Health,

Dr. Kirk Lufkin, DC

--

Kirk Lufkin, DC
Seabrook Chiropractic and Rehabilitation Center
ph:(603)474-9990 f:(603)474-9996
www.yourseabrookchiro.com



Archived: Tuesday, April 5, 2022 2:37:43 PM
From: Janelle Bard
Sent: Tuesday, February 22, 2022 11:53:10 AM
To: ~House Commerce Committee
Subject: Support HB 1245
Importance: Normal

Dear Chairman Hunt and members of the House Commerce and Consumer Affairs Committee,

My name is Dr. Janelle Bard, chiropractor and I work in Lincoln, NH. I am writing today to strongly encourage you to support HB1245, which would require that co-payments for the services of a chiropractor shall not be greater than those charged for a primary care physician or an osteopath.

For decades chiropractors are classified as "specialist" and are dealing with excessive co-pays. Chiropractors DO NOT practice like specialists, nor are they reimbursed like them. This is leading to unfair financial burdens on patients. Patients are told their insurance plans cover chiropractic, only to later learn their co-pay exceeds the actual cost of a treatment; making their ins. useless.

Please stop this and treat us on equal level as other doctors.

Thank you for your time and consideration. I urge you to support HB 1245, for the sake of patients needing our care.

Very truly yours,

Janelle L. Bard, D.C.

Dr. Janelle L. Bard
POBox 688
Lincoln, NH 03251
(603)745-2777
DrJanelleBard.com



**Report to the New Hampshire Insurance Department:
Copayments for Chiropractic Care and Physical Therapy
Services**

Prepared for the
State of New Hampshire Insurance Department

January 5, 2018

Prepared by
BerryDunn

Report to the New Hampshire Insurance Department: Copayments for Chiropractic Care and Physical Therapy Services

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This report was prepared by Devin Anderson and James P. Highland, PhD.

Report to the New Hampshire Insurance Department: Copayments for Chiropractic Care and Physical Therapy Services

1.0 Executive Summary

The state of New Hampshire passed legislation that set patients' out-of-pocket costs for chiropractic care and physical therapy services equal to out-of-pocket costs for primary care services with the goal of lowering patients' costs and increasing their access to these services. The initial study¹ conducted in December 2014 analyzed the New Hampshire Comprehensive Health Care Information System (NH CHIS) dataset in an effort to better understand this legislation, with a primary focus on the likely effects of changes in member cost. The purpose of this report is to follow up on the original study using the most complete data available. Using an updated version of the NH CHIS dataset containing roughly 230,000 commercial patients in calendar year 2016, BerryDunn performed several analyses to determine the effects of the legislation and update the original study's findings around the relationship between copayment level and use of chiropractic and physical therapy services.

The first analytical focus was on the changes over time, comparing before and after the implementation of the law. BerryDunn identified three primary findings:

- **After passage of the law, cost sharing equalized.** As expected, BerryDunn found that the legislation had a strong equalizing effect on the levels of member cost sharing, with large changes in the agreement between the empirically derived copayment levels for primary care services and the derived copayment levels of chiropractic care and physical therapy services in the populations affected by the legislation.
- **This was accomplished largely through increasing cost sharing on primary care.** BerryDunn also observed much larger secular trends away from lower-cost-sharing plans towards higher-cost-sharing plans, which produced large increases in measured cost sharing for primary care and other services. These market-wide shifts make it more difficult to discern whether the legislation had the expected effects on cost and utilization for chiropractic care and physical therapy services in the population targeted by the law.
- **Chiropractic cost sharing declined slightly and utilization increased.** Descriptive data for this population show a decline in average cost sharing and an increase in utilization for chiropractic care, but not for physical therapy. It is not feasible to establish causality about these effects, particularly given that a significant portion of the equalization in cost sharing levels between these services and other health services stem from increases to the other services' cost sharing levels, creating difficulty in

ascribing statistical significance to the small absolute changes in chiropractic care and physical therapy cost sharing levels.

The second analytical focus examined the relationship between the cost sharing level and the utilization of services within a given time period for chiropractic and PT services.

- **Lower cost sharing is associated with higher utilization for PT and chiropractic services.** The general findings from the updated analysis around the relationship between copayment level and the use of chiropractic care and physical therapy services were broadly consistent with both the findings from the first study and the landmark RAND Health Insurance Experiment (RAND HIE). Lower levels of cost sharing are associated with higher overall cost and utilization.

There is a negative and statistically significant relationship between the copayment level and the use of chiropractic care or physical therapy services. The analysis confirmed that lower copayment levels are associated with both increased likelihood of any service use during the year, and increased amount of services per patient for patients with any service use.

The study also examined the relationships between spending on chiropractic services and both spending on total services and spending on all non-chiropractic services in that same year. The study examined this same set of relationships for PT services.

- **After risk adjustment, an increase in spending on chiropractic services is associated with an increase in total spending. There was no statistically significant relationship between spending on chiropractic services and spending on non-chiropractic services.**

Similar to the original study this suggests that when considering all conditions for which chiropractic care is used, there is not enough of a reduction in other services to make up for the increase in chiropractic services spending. This results in an overall increase in total spending.

- **After risk adjustment, \$1 of PT services is associated with an increase of more than \$1 of non-PT services, though no direction of causality is established.**

This effect is much more likely to be related to unmeasured underlying morbidity for the condition being treated by physical therapy for which the model has not accounted than for an increase caused by the physical therapy services.

The third area of analytical focus was to examine the relationship between the use of chiropractic care and outcomes measures, specifically opioid use within a given year.

- **There is an association, not statistically significant, between use of chiropractic care and lower opioid use.** Similar to the initial study, there is evidence that increased

use of chiropractic care is associated with lower opioid use, however, likely due to small sample size there were no statistically significant results when analyzing the sub-population specifically affected by the legislation.

It is important to reiterate that changes in the composition and mix of the derived copayment levels used in the analysis did limit the observed effects and overall significance of the updated analyses. The market-wide shifts towards higher cost sharing across policies and plans make it difficult to draw meaningful conclusions without detailed benefit design data.

2.0 Introduction

New Hampshire House Bill 1281 required the New Hampshire Insurance Department to study the relationship of insurance copayments with use of chiropractic and physical therapy services:

“The commissioner shall compile available data and prepare reports concerning member cost sharing and the impact on utilization of services for physical therapy and chiropractic care. The first report shall...analyze all New Hampshire Insurance markets and identify differences in cost sharing and utilization of health services for the purpose of determining if there is a statistical association between the use of physical therapy and chiropractic care services and copayment amounts. The commissioner shall also seek to determine whether the overall costs of patients that utilize chiropractic care or physical therapists are less when the patient has lower copayment amounts for these services, and if any observed lower overall patient costs are caused by reductions in other health care services and better health care outcomes, not patient health status.”

NHID retained Compass Health Analytics, Inc. to perform the study, which was completed in December 2014. Additionally, the Bill required a follow up study to be done three years later using the most recently available, complete data. NHID retained BerryDunn (formerly Compass Health Analytics, Inc.) to complete the second version of the report.

The primary goal of the follow up study is to understand the impact of the legislation on member cost sharing, utilization, and overall cost for chiropractic care and physical therapy services. Additionally, the updated report re-analyzes the relationship between copayment level and use of these services.

3.0 Methods

There are four major sections of the updated study: (1) evaluation of the impacts of the legislation on copayment level for chiropractic and physical therapy services (2) evaluation of the relationship between copayment level for chiropractic and physical therapy services and use of these services, (3) evaluation of the relationship between copayment level and overall cost in patients who utilize chiropractic or physical therapy services, and (4) assessment of the relationship between use of chiropractic or physical therapy services and selected outcome measures.

The methods used in these sections other than for (1) are similar to the methods used in the original study. As such, this report provides only a brief overview for each section except in cases where there were significant methodological changes. The original report contains the complete description of each method.

3.1 Effect of the Legislation on Copayment Level for Chiropractic and PT Services

To evaluate the effects of the legislation on copayment level for chiropractic and physical therapy services BerryDunn compared the levels of agreement between primary care copayment levels and chiropractic and physical therapy copayment levels from the original study (i.e., 2013 data) to the same levels of agreement using the 2016 data. BerryDunn performed this comparison for the population overall as well as the relevant subsets, some of which were affected by the legislation and some of which were not. First BerryDunn separated out the self-funded and fully insured groups. Next BerryDunn parsed the fully insured population into individual policies, small groups, and large groups. The legislation applied to just the individual and small group markets.

BerryDunn used the same general approach for empirically assigning copayment levels as the first study. This methodology is described in more detail in the “Data” section of this report.

3.2 Relationship Between Copayment Level and Use of Chiropractic and PT Services

To evaluate the relationship between copayment level and the use of chiropractic or physical therapy services, BerryDunn used the same two-part model approach used in the first study which was similar to the methodology used in the evaluation of chiropractic services in the RAND HIE. The first part of the model uses a logistic regression to predict the likelihood of using any services, and the second part of the model evaluates the cost of services given any use of services.

BerryDunn constructed a patient-level dataset containing copayment level and cost variables for chiropractic care, physical therapy services, and overall medical and pharmacy. All cost variables were based on allowed cost, which was constructed by summing the plan paid, copayment, coinsurance, and deductible amount fields from the NH CHIS. The dataset contained data from calendar year 2016 and was limited to patients who had continuous medical eligibility and continuous enrollment in a single copayment level throughout the year.

One notable difference in methodology from the first study was around risk adjustment for patient health status. The first study used CMS’s publicly available HCC software² to assign hierarchical condition categories based on concurrent medical claims data (i.e., 2013 in the first study). The CMS HCCs are intended primarily for use in a Medicare population so were adequate but not optimal. Since the publication of the initial report, there have been several changes in the way the CMS HCCs are calculated. Annual versions of the software have resulted in changes to some of the categories. Additionally, the transition from ICD-9 diagnosis to ICD-10 diagnosis coding in October 2015 resulted in further changes to the categorizations. Since the updated study could not use exactly the same list of HCCs from the first report,

BerryDunn used HHS’s publicly available HCC software³ to assign concurrent hierarchical condition categories (i.e., based on concurrent medical claims). BerryDunn did not have access to this software during the initial study. These HCCs are conceptually similar to the CMS HCCs used previously but have the advantage of having been created for a commercial population. There is broad but not complete overlap in the categories, along with general but not complete agreement between the patient-level assignments. Using the HHS HCCs accomplishes the same goals as the first study and overall represents a methodological improvement.

The methods used in the modeling, including the use of HCCs and the transformations between log dollars and nominal dollars, were the same as the methods from the original study. The one exception is that BerryDunn did not attempt to do a longitudinal year-over-year analysis in this report since the approach was ineffective in the first study.

The final methodology difference is that in this report BerryDunn ran these models on both the full population and the population affected by the legislation.

3.3 Relationship Between Use of Chiropractic and PT Services and Overall Cost

To evaluate the relationship between chiropractic and physical therapy costs and overall costs BerryDunn used the final methodologies from the first study (i.e., BerryDunn did not replicate direct modeling attempts that were discarded due to the technical statistical problem of collinearity in the data). This general approach uses both the general copayment level and chiropractic and physical therapy costs as independent variables. The first study verified that these have a correlation but that there was not enough collinearity to invalidate the estimated effects from the models. A similar pattern occurred during this study with an even stronger effect due to the increased level of correlation between the general copayment levels and the chiropractic and physical therapy copayment levels. As was done in the first study, BerryDunn ran models with and without combinations of these independent variables and observed reasonably stable estimates. It is unlikely that the collinearity from these terms is significantly affecting the estimates from these models, but it is possible.

3.4 Assessment of the Relationship Between Use of Chiropractic or PT Services and Selected Outcome Measures

BerryDunn used the same general methods as the prior study for evaluating the relationship between chiropractic and physical therapy care and opioid use. As was the case in the first study, there are differences in the way the use of chiropractic care and the use of physical therapy services relate to opioid use, so BerryDunn modeled them separately.

The HHS HCCs contain a category for “Rheumatoid Arthritis and Specified Autoimmune Disorders” that BerryDunn used in place of the rheumatoid arthritis CMS HCC in the first study.

4.0 Data

The data source used in this study is the New Hampshire multi-payer claims database, the New Hampshire Comprehensive Health Care Information System (NH CHIS). The version of the NH CHIS data provided to BerryDunn contains detailed claims and eligibility information for individuals with Commercial or Medicaid insurance from 2014 through 2016. For this study, BerryDunn limited the sample to calendar year 2016. BerryDunn did an initial data review to limit the data only to payers that did not have obviously incomplete data (i.e., payers with plausible PMPMs and no missing paid or incurred months). Like the original study, this included removing patients eligible for Medicaid or Medicare.

Due to known discrepancies in the coverage of medical behavioral health services across payers and plans as well as concerns about the completeness and reliability of the behavioral health indicator on the medical eligibility files, BerryDunn excluded medical behavioral health payers and services (but not pharmacy claims) from the study.

As in the original study, BerryDunn used the “person_key” field within the NH CHIS data as the unit of analysis. This field is the single ID that aggregates patients who have membership in multiple plans or across multiple payers. Revisions to the available data in the 2016 CHIS allowed us to calculate an improved measure of copayment.¹

Investigation showed reasonably good consistency of copayment levels within a single group for a selected set of services. BerryDunn summarized claim lines to the claim level and examined all groups for which there were at least 10 claims of interest in the period and then used the following methodology to assign copayment levels:

- Average copayment level of \$0 was assigned to ‘Other CS’
- Average copayment of greater than \$0 and up to \$10 was assigned to ‘Low Copay’
- Average copayment of greater than \$10 and up to \$20 was assigned to ‘Med Copay’
- Average copayment of greater than \$20 was assigned to ‘High Copay’

¹ Unlike the original study, BerryDunn was able to use multiple fields when empirically assigning copayment levels. Like the prior study, the “group_id” field in the NH CHIS data was the primary field used, although the values assigned to this field changed between versions of the NH CHIS preventing longitudinal analyses at the group_id level. The 2016 version of the NH CHIS data also contains other fields that are particularly relevant to the individual policies. These fields which include “hios_plan_id,” “exchange_indicator,” and “high_deductible_health_plan” are reasonably complete and provide additional information, including high deductible classification and an indicator for whether they are exchange plans. BerryDunn was able to use these newly available fields to more accurately assign copayment levels to the individual policies, specifically using the combination of “group_id” and “hios_plan_id” for assigning copayment levels rather than “group_id” alone. Additionally, BerryDunn used the “high_deductible_health_plan” field to classify policies as ‘a) Zero Copay’ since those represent an alternative form of cost-sharing.

BerryDunn used this same method and criteria for assigning a 'Chiropractic and PT Copay Level,' 'Primary Care Copay Level,' and a 'General Copay Level' which took into account all professional services.

The correlations between copayment levels are discussed in more detail in the Results section of this report.

One major change in the underlying NH CHIS data has to do with the presence of self-funded groups. Per the 2016 U.S. Supreme Court decision, self-insured groups no longer have to submit data to state agencies.² The result of this is that there is significantly less data available for reproducing the information from the original report. This affects the ability to draw statistically significant conclusions about the relationships between copayment level and cost and utilization.

As described above, for risk adjustment BerryDunn downloaded and implemented mappings and logic for creating HHS's HCCs.¹ BerryDunn used the primary diagnosis from the available medical claims data to assign binary flags for the HCCs at the patient level.

5.0 Results

Results for each of the four study areas are presented below.

5.1 Effect of the Legislation on Copayment Level for Chiropractic and PT Services

There is significant evidence that the legislation caused greater alignment between the copayment level for chiropractic and physical therapy services and the copayment level for primary care services. There is also very strong evidence of market-wide shifts away from lower cost sharing plans into higher cost sharing plans.

There is evidence that across the full population of New Hampshire, the second effect is stronger resulting in higher levels of chiropractic and physical therapy cost sharing for individuals and small groups along with lower utilization and costs, so much of this realignment stems from increasing other cost sharing rather than decreasing cost sharing for physical therapy and chiropractic services, making it more difficult than anticipated to estimate the effects of these statutory requirements on physical therapy and chiropractic services.

In the population affected by the legislation (individuals and small groups), physical therapy copayment levels and changes in cost and utilization align with the statewide effects, but despite the challenges noted, there is suggestive evidence that the effects from the legislation

² Gobeille v. Liberty Mut. Ins. Co., 577 U.S. ____ (2016)

outweigh the secular trends for chiropractic care resulting in lower cost sharing and increased access.

As shown in Exhibit 1, for the population affected by the legislation there was a 14.5% increase in the percentage of members with an observed level of agreement between the chiropractic and physical therapy copayment level and the primary care copayment level.

Exhibit 1

For Members Affected by the Legislation, Percent with Primary Care Copay Higher, Equal to, and Lower than Chiro/PT Copay, by Year

Copay Level Relationship	2013	2016	Change
Primary Care Higher Than Chiropractic/PT	15.8%	3.0%	-12.8%
Primary Care Equal To Chiropractic/PT	82.0%	96.5%	14.5%
Primary Care Lower Than Chiropractic/PT	2.2%	0.5%	-1.7%

The population affected by the legislation also shows significant changes in the mix of copayment levels, with a shift towards plans with either higher copayment levels or into plans with alternative cost-sharing mechanisms. The plans with alternative cost sharing mechanisms appear to have higher cost sharing due to coinsurance and deductibles.

Exhibit 2

**Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Individual¹ and Small Group² Policies
Calendar Year 2013**

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	12,499	16	371	14	12,900
	Low	0	25	2,737	942	3,704
	Medium	1	10	7,191	458	7,660
	High	3	20	602	3,892	4,517
	Total	12,503	71	10,901	5,306	28,781

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	43%	0%	1%	0%	45%
	Low	0%	0%	10%	3%	13%
	Medium	0%	0%	25%	2%	27%
	High	0%	0%	2%	14%	16%
	Total	43%	0%	38%	18%	100%

**Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Individual¹ and Small Group² Policies
Calendar Year 2016**

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	43,614	420	78	370	44,482
	Low	5	335	56	106	502
	Medium	11	118	2,707	714	3,550
	High	54	32	86	9,692	9,864
	Total	43,684	905	2,927	10,882	58,398

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	75%	1%	0%	1%	76%
	Low	0%	1%	0%	0%	1%
	Medium	0%	0%	5%	1%	6%
	High	0%	0%	0%	17%	17%
	Total	75%	2%	5%	19%	100%

¹All policies sold and issued directly to individuals including group conversion policies

²All policies sold and issued directly to employers having between 1 and 50 employees

It is important to note that the “Other CS” category represents plans with alternative forms of member cost sharing mechanisms such as deductibles and coinsurance. In the original study

this category was called the “Zero” copayment level which can be misleading. This category is a heterogeneous mixture of plan types but generally appears to represent higher levels of cost sharing that occur through high deductibles and coinsurance rather than copayments.

It is also worth noting that changes in the way copayment levels are assigned for individual policies based on the new fields in the NH CHIS mean that the “Other CS” copay levels from 2013 are probably understated. However, this does not affect the agreement between primary care and chiropractic/PT copayment levels. It also does not affect the clear finding that there are very few members in 2016 in the affected population who have low or even medium copay chiropractic and physical therapy cost sharing, despite the near perfect alignment with primary care copayment levels.

One of the key findings is that the effect of the legislation on the individual and small group policies appears to be greater than the effect of the general secular trends towards greater cost sharing for chiropractic services. This comes in part from the fact that prior to the legislation there were very high cost sharing levels in the affected population.

Exhibit 3

Comparison of Key Measures for the Affected Population

		Number of Mbrs	% of Mbrs w/ Svcs	Mean Cost ¹	Mean Cost per Util Mbr ²	Member Share % on Claims w/in Service Type ³
Chiropractic or PT Services	2013	28,781	9.0%	\$62	\$687	50%
	2016	58,398	10.9%	\$60	\$551	51%
Chiropractic Services	2013	28,781	4.5%	\$17	\$379	73%
	2016	58,398	7.2%	\$25	\$342	58%
PT Services	2013	28,781	4.9%	\$45	\$902	41%
	2016	58,398	4.4%	\$35	\$805	47%

¹Cost is defined as the allowed cost for the services specified in the first column (i.e., chiropractic and PT services, chiropractic services, PT services)

²Mean Cost per Util Mbr is defined as the allowed cost divided by the total number of members who had any cost in the period

³Member Share % on Claims is defined as the sum of the copay amount, coinsurance amount, and deductible amount on the claim divided by the allowed amount of the claim

The change in cost sharing levels on chiropractic care claims are associated with higher levels of utilization indicating greater access to these services. It is worth noting that substantial

changes in the population size and health status mix could be affecting this result, but there is a strong suggestion that the legislation had the intended effect around access to chiropractic care.

The effect on physical therapy services in the individual and small group segments aligns with the secular trends seen for both chiropractic and physical therapy services in the full population, which generally show increases in cost sharing within copayment levels for both chiropractic and physical therapy services. However, Exhibit 3 makes it clear that overall cost sharing, as measured by “member share of payment,” was much higher for chiropractic than for physical therapy before the law was implemented, and the law had a much larger effect on reducing member out of pocket payments. The change in patient cost exposure for physical therapy was much smaller, and so any effects may be outweighed by other secular trends affecting physical therapy use, for example, accountable care delivery models. Physical therapy services are much more likely to be within the sphere of influence of accountable care organizations than chiropractors. In addition, under New Hampshire law, members have the option of self-referral for chiropractic services⁴.

In Exhibit 4, which displays the results for the overall population, we see that cost sharing went up very significantly for chiropractic care, and while the percentage of members using services remained largely unchanged the cost per member using service dropped dramatically. Changes in cost sharing and effects on utilization and cost for physical therapy were, again, smaller.

Exhibit 4

Comparison of Key Measures for the Full Population

		Chiropractic/ PT Copay Level	Number of Mbrs	% of Mbrs w/ Svcs	Mean Cost ¹	Mean Cost per Util Mbr ²	Median Cost per Util Mbr	Member Share % on Claims w/in Service Type ³
Chiropractic or PT Services	2013	Other CS	67,527	8.9%	\$53	\$600	\$379	44%
		Low	59,346	16.9%	\$214	\$1,264	\$445	8%
		Medium	104,312	12.9%	\$74	\$578	\$359	27%
		High	79,079	10.2%	\$55	\$537	\$337	57%
		Total	310,264	12.1%	\$92	\$756	\$381	25%
Chiropractic or PT Services	2016	Other CS	59,272	9.9%	\$55	\$558	\$372	50%
		Low	33,165	15.9%	\$108	\$676	\$400	20%
		Medium	73,441	14.1%	\$81	\$578	\$353	27%
		High	66,706	10.8%	\$55	\$508	\$344	58%
		Total	232,584	12.3%	\$71	\$574	\$363	37%
Chiropractic Services	2013	Other CS	67,527	5.6%	\$22	\$385	\$253	54%
		Low	59,346	13.0%	\$156	\$1,205	\$338	7%
		Medium	104,312	9.5%	\$35	\$371	\$263	36%
		High	79,079	5.4%	\$26	\$365	\$238	69%
		Total	310,264	8.7%	\$53	\$608	\$271	25%
Chiropractic Services	2016	Other CS	59,272	6.6%	\$22	\$328	\$246	60%
		Low	33,165	11.8%	\$48	\$409	\$274	20%
		Medium	73,441	10.7%	\$38	\$360	\$252	34%
		High	66,706	7.7%	\$27	\$351	\$252	61%
		Total	232,584	8.9%	\$32	\$361	\$255	42%
PT Services	2013	Other CS	67,527	3.7%	\$32	\$856	\$619	36%
		Low	59,346	5.1%	\$58	\$1,121	\$732	11%
		Medium	104,312	4.1%	\$39	\$946	\$665	19%
		High	79,079	3.6%	\$29	\$791	\$592	46%
		Total	310,264	4.1%	\$38	\$936	\$657	25%
PT Services	2016	Other CS	59,272	3.9%	\$33	\$858	\$644	43%
		Low	33,165	5.4%	\$60	\$1,096	\$735	19%
		Medium	73,441	4.3%	\$43	\$986	\$692	21%
		High	66,706	3.7%	\$28	\$750	\$561	54%
		Total	232,584	4.2%	\$38	\$917	\$653	32%

¹Cost is defined as the allowed cost for the services specified in the first column (i.e., chiropractic and PT services, chiropractic services, PT services)

²Mean Cost per Util Mbr is defined as the allowed cost divided by the total number of members who had any cost in the period

³Member Share % on Claims is defined as the sum of the copay amount, coinsurance amount, and deductible amount on the claim divided by the allowed amount of the claim

The original study focused on the relationship between the general copayment level and the copayment level for chiropractic and physical therapy services. The legislation tied the chiropractic and physical therapy copayment levels to primary care copayment levels rather than the general plan level. Investigation determined that the general plan and primary care copayment levels are correlated but not equivalent. Appendix A contains the full results of the analysis. It also breaks out the agreement levels by self-funded and fully insured, which clearly demonstrates the reduced data for the self-funded populations. Finally, Appendix A shows the detailed data for the copayment agreement levels for individuals, small groups, and large groups. Those tables show a much greater change in alignment between the primary care and chiropractic/PT copayment levels for the population affected by the legislation than the population not affected.

One additional finding is that the chiropractic and physical therapy copayment levels assigned in the 2016 data showed less variation than those assigned in 2013. The effect was stronger for chiropractic claims than for physical therapy claims. This suggests a shift towards more standardized copayment levels for these services. It also makes it more difficult to draw meaningful conclusions from the available data due to less distinction between the assigned plan levels. There were large reductions in the difference between the average copayment costs for low and high copayment levels. The 2016 copayment assignments for chiropractic and physical therapy services show higher average copayments in the “Low” copayment groups and lower average copayments in the “High” copayment groups.

Exhibit 5

Evaluation of Mean Copay Changes by Assigned Chiropractic and PT Copay Level

		2013	2016	Diff	% Diff
Chiropractic and Physical Therapy Claims	Low	\$4.60	\$7.16	\$2.56	
	High	\$38.57	\$36.48	-\$2.09	
	Range Low to High	\$33.97	\$29.32	-\$4.65	-14%
Chiropractic Claims	Low	\$5.53	\$8.98	\$3.45	
	High	\$37.67	\$34.80	-\$2.87	
	Range Low to High	\$32.14	\$25.82	-\$6.32	-20%
Physical Therapy Claims	Low	\$2.90	\$5.32	\$2.42	
	High	\$40.70	\$39.43	-\$1.27	
	Range Low to High	\$37.80	\$34.11	-\$3.69	-10%

The full set of updated tables shown in the original report can be found in Appendix B.

5.2 Relationship Between Copayment Level and Use of Chiropractic and Physical Therapy Services

The updated study confirms the findings of the original report with regard to the relationship between copayment level and use of chiropractic and physical therapy services. For the overall population, both the unadjusted and the modeled results are very similar. The only noteworthy difference is around a reduction in the magnitude of the relationships for chiropractic services. Specifically, the odds ratio for the likelihood of using chiropractic services for members in a low copay plan compared to members in a high copay plan dropped from 1.884 to 1.532. Similarly, of the members who used chiropractic services in a year, the estimated costs for members in a low copay plan were 49% higher than for those of members in a high copay plan in the original study but only 12% higher in the updated study. Both sets of results were still highly significant ($p < 0.001$). One possible explanation is that large reductions in the range between the low and high copayment levels shown in the previous section mean there is less distinction between the copayment levels.

The findings for the population affected by the legislation generally agree with the relationships seen in the full population. However, the smaller sample size, particularly with regard to the number of members in low copayment plans, resulted in estimates that were not statistically significant. Nevertheless, given the relationships as a whole it is highly likely that the general relationship around lower cost sharing leading to increased use of services is true for the population affected by the legislation.

The following tables show the updated unadjusted results for both the full population and the population affected by the legislation.

Exhibit 6

Unadjusted Results of Chiropractic and PT Services
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2016

		Chiropractic /PT Copay Level	Number of Mbrs	% of Mbrs w/ Svcs	Mean Cost ¹	Mean Cost per Util Mbr ²	Median Cost per Util Mbr	Mean Cost per Util Mbr in 98% Subsample
Chiropractic or PT Services	Chiropractic / PT Copay Level	Other CS	59,272	9.9%	\$55	\$558	\$372	\$528
		Low	33,165	15.9%	\$108	\$676	\$400	\$583
		Medium	73,441	14.1%	\$81	\$578	\$353	\$533
		High	66,706	10.8%	\$55	\$508	\$344	\$503
		Total	232,584	12.3%	\$71	\$574	\$363	\$534
Chiropractic Services	Chiropractic / PT Copay Level	Other CS	59,272	6.6%	\$22	\$328	\$246	\$324
		Low	33,165	11.8%	\$48	\$409	\$274	\$367
		Medium	73,441	10.7%	\$38	\$360	\$252	\$344
		High	66,706	7.7%	\$27	\$351	\$252	\$337
		Total	232,584	8.9%	\$32	\$361	\$255	\$343
PT Services	Chiropractic / PT Copay Level	Other CS	59,272	3.9%	\$33	\$858	\$644	\$808
		Low	33,165	5.4%	\$60	\$1,096	\$735	\$965
		Medium	73,441	4.3%	\$43	\$986	\$692	\$934
		High	66,706	3.7%	\$28	\$750	\$561	\$741
		Total	232,584	4.2%	\$38	\$917	\$653	\$861

¹Cost is defined as the allowed cost for the services specified in the first column (i.e., chiropractic and PT services, chiropractic services, PT services)

²Mean Cost per Util Mbr is defined as the allowed cost divided by the total number of members who had any cost in the period

Exhibit 7

Unadjusted Results of Chiropractic and PT Services
Not Self Funded Continuously Eligible Members w/ Assigned Copay Levels
Individual and Small Group Policies
Calendar Year 2016

		Chiropractic /PT Copay Level	Number of Mbrs	% of Mbrs w/ Svcs	Mean Cost ¹	Mean Cost per Util Mbr ²	Median Cost per Util Mbr	Mean Cost per Util Mbr in 98% Subsample
Chiropractic or PT Services	Chiropractic / PT Copay Level	Other CS	44,482	9.2%	\$49	\$536	\$396	\$510
		Low	502	22.1%	\$138	\$622	\$475	\$602
		Medium	3,550	18.8%	\$103	\$548	\$422	\$521
		High	9,864	14.9%	\$88	\$590	\$432	\$564
		Total	58,398	10.9%	\$60	\$551	\$396	\$526
Chiropractic Services	Chiropractic / PT Copay Level	Other CS	44,482	6.1%	\$19	\$317	\$247	\$312
		Low	502	16.1%	\$56	\$344	\$282	\$344
		Medium	3,550	13.2%	\$48	\$361	\$308	\$346
		High	9,864	9.9%	\$40	\$399	\$297	\$359
		Total	58,398	7.2%	\$25	\$342	\$266	\$327
PT Services	Chiropractic / PT Copay Level	Other CS	44,482	3.7%	\$30	\$807	\$636	\$772
		Low	502	9.6%	\$82	\$857	\$867	\$857
		Medium	3,550	7.1%	\$55	\$780	\$619	\$740
		High	9,864	6.0%	\$49	\$806	\$692	\$779
		Total	58,398	4.4%	\$35	\$805	\$643	\$772

¹Cost is defined as the allowed cost for the services specified in the first column (i.e., chiropractic and PT services, chiropractic services, PT services)

²Mean Cost per Util Mbr is defined as the allowed cost divided by the total number of members who had any cost in the period

The following tables show the updated results for the two-part models for both the full population and the population affected by the legislation.

The odds ratios show statistically significant variation between the copayment levels.

Exhibit 8

Estimated Difference Between Low and High Chiropractic/PT Copay Level
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2013

	P-Value	Odds Ratio	Odds Ratio 95% CI
Chiropractic or PT	< 0.0001	1.748	(1.693,1.804)
Chiropractic Only	< 0.0001	1.884	(1.817,1.954)
PT Only	< 0.0001	1.389	(1.318,1.464)

Estimated Difference Between Low and High Chiropractic/PT Copay Level
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2016

	P-Value	Odds Ratio	Odds Ratio 95% CI
Chiropractic or PT	< 0.0001	1.506	(1.449,1.565)
Chiropractic Only	< 0.0001	1.532	(1.466,1.601)
PT Only	< 0.0001	1.440	(1.438,1.441)

The population affected by the legislation shows similar results.

Exhibit 9

Estimated Difference Between Low and High Chiropractic/PT Copay Level
Not Self Funded Continuously Eligible Members w/ Assigned Copay Levels
Individual and Small Group Policies
Calendar Year 2016

	P-Value	Odds Ratio	Odds Ratio 95% CI
Chiropractic or PT	0.0008	1.457	(1.169,1.815)
Chiropractic Only	0.0003	1.589	(1.240,2.037)
PT Only	0.0149	1.472	(1.078,2.008)

The estimated likelihood of using services is similar to the original report.

Exhibit 10

Estimated Likelihood of Using Services by Chiropractic/PT Copay Level
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2013

	Chiropractic or Physical Therapy Services	Chiropractic Services	Physical Therapy Services
Other Cost Sharing	8.6%	5.6%	3.7%
Low Copay	16.6%	12.7%	5.1%
Medium Copay	13.0%	9.6%	4.2%
High Copay	10.2%	7.3%	3.6%

Estimated Likelihood of Using Services by Chiropractic/PT Copay Level
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2016

	Chiropractic or Physical Therapy Services	Chiropractic Services	Physical Therapy Services
Other Cost Sharing	8.6%	5.8%	3.4%
Low Copay	14.8%	10.9%	5.2%
Medium Copay	13.6%	10.4%	4.2%
High Copay	10.4%	7.4%	3.6%

The estimated likelihood of using services shows the same general pattern in the population affected by the legislation.

Exhibit 11

**Estimated Likelihood of Using Services by Chiropractic/PT Copay Level
Not Self Funded Continuously Eligible Members w/ Assigned Copay Levels
Individual and Small Group Policies
Calendar Year 2016**

	Chiropractic or Physical Therapy Services	Chiropractic Services	Physical Therapy Services
Other Cost Sharing	8.6%	5.7%	3.4%
Low Copay	20.7%	15.1%	8.6%
Medium Copay	19.5%	13.6%	7.2%
High Copay	15.2%	10.1%	6.0%

The second part of the two-part model (cost) shows similar results to the original report. For chiropractic services there is much less difference between the low and high copayment levels which is likely due in part to the smaller differences between the average copay levels in those categories.

Exhibit 12

**Estimated Cost Differences of Utilizing Members by Chiropractic/PT Copay Level
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2013**

	Chiropractic or Physical Therapy Services	Chiropractic Services	Physical Therapy Services
Zero Copay	\$681	\$489	\$861
Low Copay	\$874	\$706	\$1,057
Medium Copay	\$656	\$497	\$942
High Copay	\$628	\$474	\$820
Low - High	\$246	\$232	\$237
% Diff Low/High	39%	49%	29%
Diff P-Value	< 0.0001	< 0.0001	< 0.0001

**Estimated Cost Differences of Utilizing Members by Chiropractic/PT Copay Level
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2016**

	Chiropractic or Physical Therapy Services	Chiropractic Services	Physical Therapy Services
Zero Copay	\$511	\$304	\$789
Low Copay	\$586	\$354	\$967
Medium Copay	\$520	\$330	\$886
High Copay	\$487	\$317	\$714
Low - High	\$99	\$37	\$253
% Diff Low/High	20%	12%	35%
Diff P-Value	< 0.0001	< 0.0001	< 0.0001

However, there are no statistically significant results in the population affected by the legislation.

Exhibit 13

**Estimated Cost Differences of Utilizing Members by Chiropractic/PT Copay Level
All Continuously Eligible Members w/ Assigned Copay Levels
Individual and Small Group Policies
Calendar Year 2016**

	Chiropractic or Physical Therapy Services	Chiropractic Services	Physical Therapy Services
Other Cost Sharing	\$514	\$305	\$773
Low Copay	\$642	\$332	\$882
Medium Copay	\$559	\$354	\$775
High Copay	\$593	\$365	\$819
Low - High	\$49	-\$33	\$63
% Diff Low/High	8%	-9%	8%
Diff P-Value	0.4325	0.3727	0.5892

5.3 Relationship Between Use of Chiropractic and Physical Therapy Services and Overall Cost

The updated analysis shows reasonably good agreement with the prior analysis for both the full population and the population affected by the legislation. Higher use of chiropractic services in patients with any chiropractic services is statistically significantly related ($p < 0.0001$) to higher overall cost after controlling for age, gender, health status, and plan design. However, unlike the original study, there was no statistically significant relationship between the amount of use of chiropractic services used by patients who had any chiropractic care and the non-chiropractic costs of those patients. This difference between the two studies could be the result of the changes in the copayment levels. Taken together, the likely conclusion is that an increase in chiropractic care will lead to higher overall costs and that any substitution effects will not completely offset the cost of the chiropractic services.

As was seen in the prior study, administrative claims data do not have the information necessary to support risk-adjusted analyses of the effect of physical therapy on overall cost. General health status adjustments from claims data without clinical information, such as functional status or severity indexes, do not accurately capture the underlying morbidity for the specific condition that led the patient to utilize physical therapy services. The HCCs were designed to capture a wide range of conditions that contribute to overall cost. The HCCs set up hierarchies within some conditions in order to account for increased severity of related illnesses, but not all of the conditions have these hierarchies and it's possible that more detailed clinical information than is available in administrative claims data would be needed in order to accurately assign severity levels to all conditions. For example, rheumatoid arthritis is a single HCC but is a disease that tends to progress to other functional areas and result in joint damage over time, and costs per patient would be expected to have a wide range of severity within this category. Controlling for age, gender, and general health status the analysis finds that increased use of physical therapy services in patients with any physical therapy is statistically significantly related to both higher overall costs and higher non-physical therapy costs (both $p < 0.0001$). Examination of the results again shows an increase of \$1 in physical therapy cost corresponds to an increase in overall cost far greater than \$1. This correlation does not establish causation. An effect that large is much more likely to be related to unmeasured underlying morbidity for the condition being treated by physical therapy for which the model has not accounted than for an increase caused by the physical therapy services.

5.4 Relationship Between Use of Chiropractic and PT Services and Outcomes

Like the original report, the updated analysis focuses on the relationship between chiropractic and physical therapy services and opioid use and again analyzes chiropractic care and physical therapy services separately. The analysis examined four opioid use outcomes in patients with a diagnosis of rheumatoid arthritis: any opioid use, opioid use for 30+ days, opioid use for 90+

days, and the total days for patients who had any days of opioid use. BerryDunn ran these analyses for both the full population and the subset of the population affected by the legislation.

The results for the full population generally align with the results from the original study. In all four outcomes, either the use of chiropractic services or the amount of chiropractic services received were nominally related to reductions in the outcomes of interest. However, there were lower levels of statistical significance across these outcomes. Neither of the opioid use models were significant. The opioid use for 30+ days models had p-values of 0.1308 and 0.0518 for use of chiropractic services and amount of chiropractic services respectively. The opioid use for 90+ days models had p-values of 0.0991 and 0.0398 for use of chiropractic services and amount of chiropractic services respectively. The total days for patients who had any days of opioid use models had p-values of 0.0177 and <0.0001 for use of chiropractic services and amount of chiropractic services respectively.

For the full population the use of physical therapy services and the amount of physical therapy services used were both statistically significantly related to an increased likelihood of any opioid use and long-term opioid use, with p-values ranging from < 0.0001 to 0.0544. There was no statistically significant relationship between either use of physical therapy services ($p = 0.91$) or the amount of physical therapy services ($p = 0.82$) used and the total days of opioid use in patients who had any opioid use.

There were no statistically significant results when analyzing only the population affected by the legislation.

The analysis uses a health status risk adjustment that is based only on administrative claims data and does not have access to clinical information. The analysis assumes homogeneity of severity/patient risk within patients with a diagnosis of rheumatoid arthritis, but the observed associations between chiropractic care and opioid use and physical therapy and opioid use could be the result of underlying population differences for which the analysis has not controlled.

6.0 Conclusions

The results of the updated study show that the legislation did result in a significantly greater alignment between the primary care copayment levels and the chiropractic and physical therapy copayment levels. The study also showed that market trends have shifted most plans, especially those in the affected population, away from lower cost sharing plans and towards higher cost sharing plans. This effect appears to be larger than the effect of the legislation, with the result that very few members have what the first study classified as “low” chiropractic and physical therapy costs. These large changes make the impact of the legislation on member cost and utilization unclear.

The results of the follow-up study confirm the findings from the original study that there is a negative and statistically significant relationship between the copayment level and the use of chiropractic care or physical therapy services. The analysis confirmed that lower copayment levels are associated with both increased likelihood of using the services and increased amount of services used for patients with any service use. This is true for both chiropractic care and physical therapy services and is true after controlling for age, gender, and health status.

The study also confirmed that an increase in either chiropractic care costs or an increase in physical therapy costs is statistically significantly related to increases in overall costs. It is possible that chiropractic care has partial substitution effects for medical services. There is strong evidence that risk adjustment using information not available through administrative claims data is needed in order to determine if physical therapy costs offset other medical or pharmacy costs.

Similarly, the outcome measures evaluated in this study may require additional risk adjustment. There is evidence that increased use of chiropractic care is associated with lower opioid use and that increased use of physical therapy services is associated with increased opioid use, but it is unclear whether these differences are due to underlying differences in patient severity.

Overall, in the commercially insured population in New Hampshire, lower copayment levels for chiropractic and physical therapy services are associated with increased likelihood of using and increased amount of use of those services as well as higher overall patient costs. Through the evaluation of the 'Other CS' plans, there is evidence that cost sharing through mechanisms such as coinsurance and deductibles to some extent behave similarly.

It is important to note that although this analysis shows a relationship between lower copayment for chiropractic and physical therapy services and increased use of and cost of both these services and overall medical and pharmacy costs, it is a cross-sectional study that shows correlation not causation. There could be selection bias effects (i.e., patients more likely to use services self-select into plans with lower copayment levels). This study also only analyzes direct costs, and does not consider other societal benefits such as reduced worker absenteeism. Finally, the value proposition for medical services needs to consider costs, both direct and indirect, but also quality, patient outcomes, and patient satisfaction. The research literature supports significant patient outcome benefits and patient satisfaction in use of both chiropractic and physical therapy services.

Appendix A

The following tables show the results of the copayment level analyses and comparisons.

Update to original analysis showing fairly good agreement.

**Crosstab of Chiro/PT Copay Level vs. Professional Services Copay Level:
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2013**

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	36,111	26,359	4,120	937	67,527
	Low	0	45,633	12,093	1,620	59,346
	Medium	0	26,409	77,800	103	104,312
	High	0	5,199	61,608	12,272	79,079
	Total	36,111	103,600	155,621	14,932	310,264

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	12%	8%	1%	0%	22%
	Low	0%	15%	4%	1%	19%
	Medium	0%	9%	25%	0%	34%
	High	0%	2%	20%	4%	25%
	Total	12%	33%	50%	5%	100%

**Crosstab of Chiro/PT Copay Level vs. Professional Services Copay Level:
All Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2016**

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	53,121	4,491	1,483	177	59,272
	Low	0	31,737	1,344	84	33,165
	Medium	0	19,276	53,895	270	73,441
	High	0	2,075	51,077	13,554	66,706
	Total	53,121	57,579	107,799	14,085	232,584

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	23%	2%	1%	0%	25%
	Low	0%	14%	1%	0%	14%
	Medium	0%	8%	23%	0%	32%
	High	0%	1%	22%	6%	29%
	Total	23%	25%	46%	6%	100%

There was a significant reduction in the size of the self-funded population.

**Crosstab of Chiro/PT Copay Level vs. Professional Services Copay Level:
Self Funded Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2013**

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	17,231	22,161	2,473	879	42,744
	Low	0	41,414	8,341	1,596	51,351
	Medium	0	24,335	56,068	60	80,463
	High	0	3,939	22,850	779	27,568
	Total	17,231	91,849	89,732	3,314	202,126

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	9%	11%	1%	0%	21%
	Low	0%	20%	4%	1%	25%
	Medium	0%	12%	28%	0%	40%
	High	0%	2%	11%	0%	14%
	Total	9%	45%	44%	2%	100%

**Crosstab of Chiro/PT Copay Level vs. Professional Services Copay Level:
Self Funded Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2016**

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	3,632	269	214		4,115
	Low	0	28,750	351		29,101
	Medium	0	15,990	41,966		57,956
	High	0	849	8,222	202	9,273
	Total	3,632	45,858	50,753	202	100,445

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	4%	0%	0%	0%	4%
	Low	0%	29%	0%	0%	29%
	Medium	0%	16%	42%	0%	58%
	High	0%	1%	8%	0%	9%
	Total	4%	46%	51%	0%	100%

The fully-insured population is more comparable.

Crosstab of Chiro/PT Copay Level vs. Professional Services Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2013

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	18,880	4,198	1,647	58	24,783
	Low	4,219	3,752	24		7,995
	Medium		2,074	21,732	43	23,849
	High		1,260	38,758	11,493	51,511
	Total	18,880	11,751	65,889	11,618	108,138

Crosstab of Chiro/PT Copay Level vs. Professional Services Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2016

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	49,489	4,222	1,269	177	55,157
	Low		2,987	993	84	4,064
	Medium		3,286	11,929	270	15,485
	High		1,226	42,855	13,352	57,433
	Total	49,489	11,721	57,046	13,883	132,139

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	17%	4%	2%	0%	23%
	Low	0%	4%	3%	0%	7%
	Medium	0%	2%	20%	0%	22%
	High	0%	1%	36%	11%	48%
	Total	17%	11%	61%	11%	100%

		General Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	37%	3%	1%	0%	42%
	Low	0%	2%	1%	0%	3%
	Medium	0%	2%	9%	0%	12%
	High	0%	1%	32%	10%	43%
	Total	37%	9%	43%	11%	100%

The chiropractic/PT copayment level shows much stronger agreement with the primary care copayment level than with the general copayment level.

Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2013

		Primary Care Visit Copay Level					
		Other CS	Low	Medium	High	Total	
Chiropractic / PT Copay Level	Other CS	22,412	403	1,623	345	24,783	
	Low		1,270	5,375	1,350	7,995	
	Medium		1	468	21,808	1,572	23,849
	High		18	20	5,330	46,143	51,511
	Total	22,431	2,161	34,136	49,410	108,138	

Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Calendar Year 2016

		Primary Care Visit Copay Level					
		Other CS	Low	Medium	High	Total	
Chiropractic / PT Copay Level	Other CS	52,717	671	616	1,153	55,157	
	Low		9	2,490	1,307	258	4,064
	Medium		11	619	12,092	2,763	15,485
	High		93	130	2,424	54,786	57,433
	Total	52,830	3,910	16,439	58,960	132,139	

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	21%	0%	2%	0%	23%
	Low	0%	1%	5%	1%	7%
	Medium	0%	0%	20%	1%	22%
	High	0%	0%	5%	43%	48%
	Total	21%	2%	32%	46%	100%

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	40%	1%	0%	1%	42%
	Low	0%	2%	1%	0%	3%
	Medium	0%	0%	9%	2%	12%
	High	0%	0%	2%	41%	43%
	Total	40%	3%	12%	45%	100%

As expected, there is very strong agreement between the primary care and the chiropractic/PT copayment level in the individual policies population.

For Individual Policies, Percent with Primary Care Copay Higher, Equal to, and Lower than Chiro/PT Copay, by Year

Copay Level Relationship	2013	2016	Change
Primary Care Higher Than Chiropractic/PT	18%	2%	-16%
Primary Care Equal To Chiropractic/PT	81%	98%	17%
Primary Care Lower Than Chiropractic/PT	1%	0%	-1%

Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Individual Policies¹
Calendar Year 2013

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	10,382				10,382
	Low			2,648	899	3,547
	Medium			6,558	410	6,968
	High			162	1,042	1,204
	Total	10,382	0	9,368	2,351	22,101

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	47%	0%	0%	0%	47%
	Low	0%	0%	12%	4%	16%
	Medium	0%	0%	30%	2%	32%
	High	0%	0%	1%	5%	5%
	Total	47%	0%	42%	11%	100%

Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Individual Policies¹
Calendar Year 2016

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	40,544	389	47	164	41,144
	Low		331			331
	Medium			535	275	810
	High				3,347	3,347
	Total	40,544	720	582	3,786	45,632

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	89%	1%	0%	0%	90%
	Low	0%	1%	0%	0%	1%
	Medium	0%	0%	1%	1%	2%
	High	0%	0%	0%	7%	7%
	Total	89%	2%	1%	8%	100%

¹All policies sold and issued directly to individuals including group conversion policies

There is also strong agreement in the small group population.

For Small Groups, Percent with Primary Care Copay Higher, Equal to, and Lower than Chiro/PT Copay, by Year

Copay Level Relationship	2013	2016	Change
Primary Care Higher Than Chiropractic/PT	9%	7%	-2%
Primary Care Equal To Chiropractic/PT	84%	91%	7%
Primary Care Lower Than Chiropractic/PT	7%	2%	-5%

Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Small Group Policies¹
Calendar Year 2013

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	2,117	16	371	14	2,518
	Low		25	89	43	157
	Medium	1	10	633	48	692
	High	3	20	440	2,850	3,313
	Total	2,121	71	1,533	2,955	6,680

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	32%	0%	6%	0%	38%
	Low	0%	0%	1%	1%	2%
	Medium	0%	0%	9%	1%	10%
	High	0%	0%	7%	43%	50%
	Total	32%	1%	23%	44%	100%

Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Small Group Policies¹
Calendar Year 2016

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	3,070	31	31	206	3,338
	Low	5	4	56	106	171
	Medium	11	118	2,172	439	2,740
	High	54	32	86	6,345	6,517
	Total	3,140	185	2,345	7,096	12,766

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	24%	0%	0%	2%	26%
	Low	0%	0%	0%	1%	1%
	Medium	0%	1%	17%	3%	21%
	High	0%	0%	1%	50%	51%
	Total	25%	1%	18%	56%	100%

¹All policies sold and issued directly to employers having between 1 and 50 employees

There is a smaller shift and less overall agreement in the large group population.

For Large Groups, Percent with Primary Care Copay Higher, Equal to, and Lower than Chiro/PT Copay, by Year

Copay Level Relationship	2013	2016	Change
Primary Care Higher Than Chiropractic/PT	7%	7%	0%
Primary Care Equal To Chiropractic/PT	86%	89%	3%
Primary Care Lower Than Chiropractic/PT	7%	4%	-3%

Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Large Group Policies¹
Calendar Year 2013

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	9,661	314	513	248	10,736
	Low		1,237	2,638	387	4,262
	Medium		451	14,191	1,114	15,756
	High		15	4,406	38,782	43,203
	Total		9,676	2,002	21,748	40,531

Crosstab of Chiro/PT Copay Level vs. Primary Care Visits Copay Level:
Fully Insured Continuously Eligible Members w/ Assigned Copay Levels
Large Group Policies¹
Calendar Year 2016

		Primary Care Visit Copay Level					
		Other CS	Low	Medium	High	Total	
Chiropractic / PT Copay Level	Other CS	9,093	251	538	783	10,665	
	Low		4	2,155	1,251	3,562	
	Medium			501	9,385	2,049	11,935
	High		39	98	2,338	45,061	47,536
	Total		9,136	3,005	13,512	48,045	73,698

		Primary Care Visit Copay Level				
		Other CS	Low	Medium	High	Total
Chiropractic / PT Copay Level	Other CS	13%	0%	1%	0%	15%
	Low		0%	2%	4%	6%
	Medium		0%	1%	19%	21%
	High		0%	0%	6%	52%
	Total		13%	3%	29%	55%

		Primary Care Visit Copay Level					
		Other CS	Low	Medium	High	Total	
Chiropractic / PT Copay Level	Other CS	12%	0%	1%	1%	14%	
	Low		0%	3%	2%	5%	
	Medium		0%	1%	13%	3%	16%
	High		0%	0%	3%	61%	65%
	Total		12%	4%	18%	65%	100%

¹All policies sold and issued directly to employers having more than 50 employees

Appendix B

Evaluation of Copay on Chiropractic and PT Claims by Assigned Chiropractic and PT Copay Level Calendar Year 2016

		N	Copay Mode	Copay Quartile1	Copay Median	Copay Quartile3	Copay Mean	Coins Mean	Deduct Mean
Chiropractic / PT Copay Level	Other CS	26,952	\$0.00	\$0.00	\$0.00	\$0.00	\$3.70	\$1.22	\$31.00
	Low	63,635	\$0.00	\$0.00	\$5.00	\$10.00	\$7.16	\$0.49	\$3.64
	Medium	87,308	\$20.00	\$15.00	\$15.00	\$20.00	\$16.69	\$0.24	\$1.29
	High	51,302	\$25.00	\$25.00	\$36.01	\$50.00	\$36.48	\$0.14	\$1.22
	Total	229,197	\$0.00	\$0.00	\$15.00	\$25.00	\$16.70	\$0.45	\$7.30

Evaluation of Copay on Chiropractic Claims by Assigned Chiropractic and PT Copay Level Calendar Year 2016

		N	Copay Mode	Copay Quartile1	Copay Median	Copay Quartile3	Copay Mean	Coins Mean	Deduct Mean
Chiropractic / PT Copay Level	Other CS	13,350	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.81	\$35.49
	Low	36,583	\$0.00	\$0.00	\$5.00	\$10.00	\$8.98	\$0.39	\$7.96
	Medium	53,009	\$20.00	\$15.00	\$20.00	\$20.00	\$18.38	\$0.22	\$1.19
	High	31,476	\$25.00	\$25.00	\$30.00	\$40.00	\$34.80	\$0.12	\$1.00
	Total	134,418	\$0.00	\$5.00	\$15.00	\$25.00	\$17.84	\$0.30	\$6.39

Evaluation of Copay on Physical Therapy Claims by Assigned Chiropractic and PT Copay Level Calendar Year 2016

		N	Copay Mode	Copay Quartile1	Copay Median	Copay Quartile3	Copay Mean	Coins Mean	Deduct Mean
Chiropractic / PT Copay Level	Other CS	13,602	\$0.00	\$0.00	\$0.00	\$0.00	\$0.03	\$1.64	\$36.39
	Low	27,052	\$0.00	\$0.00	\$0.00	\$10.00	\$5.32	\$1.06	\$8.81
	Medium	34,299	\$20.00	\$0.00	\$15.00	\$20.00	\$14.65	\$0.26	\$1.56
	High	19,826	\$50.00	\$25.00	\$40.00	\$50.00	\$39.43	\$0.16	\$1.38
	Total	94,779	\$0.00	\$0.00	\$10.00	\$20.00	\$15.07	\$0.66	\$8.59

Evaluation of Copay on Chiropractic and PT Claims by Assigned Chiropractic and PT Copay Level
Calendar Year 2013

Chiropractic / PT Copay Level		N	Copay Mode	Copay Quartile1	Copay Median	Copay Quartile3	Copay Mean	Coins Mean	Deduct Mean
		Other CS	49,329	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Low	96,011	\$0.00	\$0.00	\$0.00	\$0.00	\$5.00	\$4.60	\$1.64	\$4.14
Medium	110,998	\$20.00	\$10.00	\$15.00	\$20.00	\$20.00	\$16.43	\$0.62	\$1.94
High	60,815	\$50.00	\$25.00	\$38.39	\$50.00	\$50.00	\$38.57	\$0.32	\$1.82
Total	317,153	\$0.00	\$0.00	\$10.00	\$20.00	\$20.00	\$14.54	\$1.36	\$14.54

Evaluation of Copay on Chiropractic Claims by Assigned Chiropractic and PT Copay Level
Calendar Year 2013

Chiropractic / PT Copay Level		N	Copay Mode	Copay Quartile1	Copay Median	Copay Quartile3	Copay Mean	Coins Mean	Deduct Mean
		Other CS	24,976	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Low	62,488	\$0.00	\$0.00	\$5.00	\$10.00	\$5.53	\$1.42	\$3.22	
Medium	67,840	\$20.00	\$15.00	\$15.00	\$20.00	\$17.44	\$0.63	\$1.55	
High	35,966	\$25.00	\$25.00	\$38.02	\$45.00	\$37.67	\$0.35	\$1.76	
Total	191,270	\$0.00	\$0.00	\$10.00	\$20.00	\$15.08	\$1.19	\$5.64	

Evaluation of Copay on Physical Therapy Claims by Assigned Chiropractic and PT Copay Level
Calendar Year 2013

Chiropractic / PT Copay Level		N	Copay Mode	Copay Quartile1	Copay Median	Copay Quartile3	Copay Mean	Coins Mean	Deduct Mean
		Other CS	24,353	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Low	33,523	\$0.00	\$0.00	\$0.00	\$0.00	\$5.00	\$2.90	\$2.07	\$5.93
Medium	43,158	\$20.00	\$10.00	\$15.00	\$20.00	\$15.01	\$0.61	\$2.58	
High	24,849	\$50.00	\$25.00	\$40.00	\$50.00	\$40.70	\$0.28	\$1.95	
Total	125,883	\$0.00	\$0.00	\$5.00	\$20.00	\$13.92	\$1.66	\$8.26	

Evaluation of Copay on Professional Claims by General Copay Level
Calendar Year 2013

Chiropractic / PT Copay Level		N	Copay Mode	Copay Quartile1	Copay Median	Copay Quartile3	Copay Mean	Coins Mean	Deduct Mean
		Other CS	58,750	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.01
Low	211,947	\$0.00	\$0.00	\$0.00	\$10.00	\$4.97	\$1.75	\$15.73	
Medium	294,927	\$0.00	\$0.00	\$15.00	\$20.00	\$13.83	\$1.04	\$8.22	
High	26,594	\$25.00	\$0.00	\$25.00	\$30.00	\$22.69	\$0.35	\$14.57	
Total	592,218	\$0.00	\$0.00	\$0.00	\$20.00	\$9.68	\$1.64	\$16.40	

Endnotes

¹ The original study can be found on the New Hampshire Insurance Department's website:
https://www.nh.gov/insurance/reports/documents/chiro_pt_copay.pdf

² HCCs are created by and are the property of CMS and are publicly available on their website:
<http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2013.html?DLPage=1&DLSort=0&DLSortDir=descending>

³ HCCs are created by and are the property of HHS and are publicly available on their website:
<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/DIY-Instructions-2017-RA-7-20-17.pdf>

⁴ Per New Hampshire law, members are allowed to self-refer for chiropractic services:
<http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-6-b.htm>

Archived: Wednesday, March 16, 2022 11:17:00 AM
From: Cameron Lapine
Sent: Tuesday, January 11, 2022 2:00:40 PM
To: ~House Judiciary Committee; Ned Gordon
Subject: HB 1245 and HB 1216-FN Testimony - Senator Perkins Kwoka
Importance: Normal
Attachments:
Senator Perkins Kwoka - HB 1245 and HB 1216 Testimony.docx ;

Good Afternoon,

Please find attached written testimony from Senator Perkins Kwoka regarding HB 1245 and HB 1216-FN.

Please let me know if I can be of any further assistance.

Best,
Cameron M. Lapine
Senate Legislative Aide

Senator David Watters (District 4)
Senator Rebecca Perkins Kwoka (District 21)
Senate Health and Human Services Committee

Cameron.lapine@leg.state.nh.us
603-271-2104

Archived: Wednesday, March 16, 2022 11:07:03 AM
From: Cameron Lapine
Sent: Tuesday, January 11, 2022 2:00:40 PM
To: ~House Judiciary Committee; Ned Gordon
Subject: HB 1245 and HB 1216-FN Testimony - Senator Perkins Kwoka
Importance: Normal
Attachments:
Senator Perkins Kwoka - HB 1245 and HB 1216 Testimony.docx ;

Good Afternoon,

Please find attached written testimony from Senator Perkins Kwoka regarding HB 1245 and HB 1216-FN.

Please let me know if I can be of any further assistance.

Best,
Cameron M. Lapine
Senate Legislative Aide

Senator David Watters (District 4)
Senator Rebecca Perkins Kwoka (District 21)
Senate Health and Human Services Committee

Cameron.lapine@leg.state.nh.us
603-271-2104

Archived: Thursday, May 19, 2022 12:44:35 PM
From: Brendan McCann
Sent: Tuesday, February 15, 2022 9:47:18 AM
To: ~House Commerce Committee
Subject: HB 1245 In-network cost sharing
Importance: Normal

Good morning members of the Commerce Committee,

Thank you for the time and consideration which I understand you've spent on HB 1245 following the recent hearing. As clinicians serving New Hampshire residents throughout the state, we genuinely appreciate the effort you put into ensuring good health care access for consumers. You may have read the letter that I previously submitted via Rep. Love (attached). It laid out a few studies related to the economics of chiropractic access, which showed cost savings and decreased pain-related opioid use, reflective of the broader findings in this field of study.

As you consider this issue for a vote (which I understand to be coming up this week), I wanted to make myself available to you all. I've spent a lot of time talking to community members, office staff, clinicians, and researchers about the effects of access to conservative pain management. Your time is finite, and if you would like to discuss any aspect of consumer experiences or the research literature, please feel free to get in touch.

Please vote to support HB 1245, and ensure access to conservative pain management options using a market-based incentive approach.

You can respond to this email address, or call me at 207-370-9342, and I'll get back to you as soon as I'm between patients.

Again, many thanks for your efforts.

Sincerely,

Brendan McCann, D.C.

President

New Hampshire Chiropractic Association

Alternate Delegate, State Affiliate Representative

American Chiropractic Association



Chiropractic : Association

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House Committee on Commerce and Consumer Affairs
HB 1245

February 2, 2022

Dear Chair Hunt and members of the committee,

Earlier today you heard verbal testimony from two of my colleagues in support of HB 1245. I write to provide documentation supporting some of the claims that they presented today.

There is a LOT of literature that has looked at the issue of chiropractic access and health outcomes, a great deal of it using data from New Hampshire. Over time and geography a great majority showed cost savings, improved patient satisfaction, and lower opioid use among patients with first-line access to chiropractors.

The present challenge to patients is that plans treat chiropractors as specialists for the purpose of deciding co-pays. However, patients do not access chiropractors as specialists, like a gastroenterologist seen only one or two times for niche diagnostics and expensive therapies. Rather, patients see us as first-line care, for problems where an ongoing relationship improves, with higher value than specialist care due to lower costs (more improvement for your buck).

Consumers need to be able to afford a series of visits, and not be incentivized to crowd specialist offices instead of seeing well-qualified doctors of chiropractic who can manage their pain. This improves the whole healthcare delivery system, as it lets specialists do their job best.

A great example: today I saw a patient with chronic headaches. A specialist ruled out any serious pathology and then discharged her without treatment because, he told her, "If I managed routine headaches my office would be full of nothing else." This is a case easily managed in my office.

For your interest, I have provided summary and links to three representative studies that support improved access to chiropractors using co-pays equivalent to primary care services:

1. Coverage of Nonpharmacologic Treatments for Low Back Pain Among US Public and Private Insurers (Heyward 2018)

<https://pubmed.ncbi.nlm.nih.gov/30646222/>

NHCA Chiropractic Association

Summary: Costs of access should be considered based on different treatment options for the same problem - what do payers want to drive those consumers to? They should want to drive them to conservative care, not expensive specialists - and they can help consumers make that decision by using co-pays equivalent to other first line care.

"Interviews with plan executives indicated a low level of integration between the coverage decision-making processes for pharmacologic and nonpharmacologic therapies for chronic pain."

2. The association between use of chiropractic care and costs of care (Weeks 2016)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4834378/>

Summary: stated explicitly, that the cost of care of spine pain was lower when patients had access to chiropractic care.

"This study found that... patients who used only CMT during their chronic LBP episodes had lower overall costs of care, shorter episodes, and lower cost of care per episode day than patients in the other treatment groups."

3. Impact of Chiropractic Care on Use of Prescription Opioids in Patients with Spinal Pain (Whedon 2020)

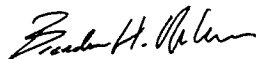
<https://academic.oup.com/painmedicine/article/21/12/3567/5788462>

Summary: 2020 Dartmouth-based study using NH data, showed that when chiropractic care was as accessible as primary care, their likelihood of getting opioids was cut in HALF.

"Patients with spinal pain who saw a chiropractor had half the risk of filling an opioid prescription. Among those who saw a chiropractor within 30 days of diagnosis, the reduction in risk was greater."

I urge you to work with us in the New Hampshire Chiropractic Association to get this done. If you would like further information on this issue, or pertinent data or research, please feel free to contact me.

Sincerely,



Brendan McCann, DC, PSP
NHCA President

**Report to the New Hampshire Insurance Department: Copayments
for Chiropractic Care and Physical Therapy Services**

Prepared for the
State of New Hampshire Insurance Department

December 12, 2014

Prepared by
Compass Health Analytics, Inc.



Report to the New Hampshire Insurance Department: Copayments for Chiropractic Care and Physical Therapy Services

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This report was prepared by Devin Anderson and James P. Highland, PhD.

Report to the New Hampshire Insurance Department: Copayments for Chiropractic Care and Physical Therapy Services

Executive Summary

The state of New Hampshire has proposed legislation that increases patients' access to chiropractic care and physical therapy services by lowering patient out-of-pocket costs. The purpose of this study is to better understand the impact of this legislation, specifically how the member cost sharing changes are likely to affect both cost and utilization for these services as well as their impact on overall cost. Using the NH CHIS dataset, Compass used empirical methods to assign copayment levels to roughly 300,000 commercial patients in calendar year 2013 and then performed several analyses to determine the relationship between copayment level and use of chiropractic and physical therapy services.

Consistent with the results found in the landmark RAND Health Insurance Experiment (RAND HIE), Compass found that for both chiropractic and physical therapy services lower copayment levels were associated with higher spending on those services.

The relationship between copayment level and overall combined medical and pharmacy cost for patients who used chiropractic or physical therapy services is more complex. For patients who used chiropractic services, increased use of chiropractic services corresponded to a statistically significant increase in overall cost. However, there was also a smaller but statistically significant relationship between increased chiropractic costs and lower non-chiropractic costs. As has been demonstrated for specific conditions in the literature¹, this finding suggests that there is a partial substitution effect between chiropractic services and other medical services, although not enough to offset the system-wide cost of chiropractic care.

For patients who used physical therapy services, there was a statistically significant increase in both non-physical therapy cost and overall medical cost associated with increased use of physical therapy services. However, it is very likely that the risk adjustment used in the model did not adequately adjust for the underlying health status of the population that used physical therapy services.

Finally, Compass examined the relationship between chiropractic and physical therapy services and several outcome measures related to opioid use. Again, consistent with past studies,² Compass found that any use of and the amount of use of chiropractic care was associated with lower use of opioids. Compass also found that any use of and the amount of use of physical therapy services was associated with higher opioid use. However, data related to the severity of the conditions requiring pain management were not available. As a result, the relationship between physical therapy services and opioid use outcomes could be the result of failing to properly control for the morbidity in the underlying population. This portion of the analysis does not establish causation between use of physical therapy services and opioid use.

The results of the study as a whole indicate that copayment level and use of chiropractic and physical therapy services are related, and that, although the results of the study could be limited by selection bias, it is likely that lowering copayment levels will lead to increased use of these services, which will likely lead to higher overall costs that are not completely offset by reductions in costs for other services.

Introduction

New Hampshire House Bill 1281 requires the New Hampshire Insurance Department (the Department) to study the relationship of insurance copayments with use of chiropractic and physical therapy services:

“The commissioner shall compile available data and prepare reports concerning member cost sharing and the impact on utilization of services for physical therapy and chiropractic care. The first report shall...analyze all New Hampshire Insurance markets and identify differences in cost sharing and utilization of health services for the purpose of determining if there is a statistical association between the use of physical therapy and chiropractic care services and copayment amounts. The commissioner shall also seek to determine whether the overall costs of patients that utilize chiropractic care or physical therapists are less when the patient has lower copayment amounts for these services, and if any observed lower overall patient costs are caused by reductions in other health care services and better health care outcomes, not patient health status.”

The Department retained Compass Health Analytics, Inc. to perform the requested study, and this document presents the results of that study.

Current estimates from the National Center for Health Statistics indicate that 8.5% of adults in the United States use chiropractic care in a 12 month period.³ In addition, lower back pain is one of the most prevalent diagnoses in the United States, with an estimated 31 million Americans experiencing low-back pain at any given time.⁴ There are substantial direct and indirect costs, such as worker absenteeism, associated with this condition that are expected to increase as the population ages.^{5,6} Studies have shown that chiropractic care and physical therapy can be effectively used to treat this prevalent condition.⁷

Past studies have shown that chiropractic care is sensitive to levels of cost sharing.⁸ The results of the landmark federally-funded health insurance experiment conducted by the RAND Corporation (RAND HIE) indicated that both the likelihood of using any services and the amount of services used were higher at lower levels of cost sharing.⁹ The proposed legislation in New Hampshire states that cost sharing mechanisms such as copayments, coinsurance, and office visit deductibles for chiropractors and physical therapists cannot be greater than the copayments, coinsurance, and office visit deductibles for primary care physicians. This study uses data from the state of New Hampshire to evaluate the relationship between copayment level and use of chiropractic and physical therapy services.

Additionally, the proposed legislation seeks to understand the relationship between chiropractic and physical therapy copayment levels and the overall costs for patients who utilize those services. Studies of cost-effectiveness for various methods of treating conditions like low-back pain have reached conflicting results,¹⁰ though there is evidence that for certain conditions treated by chiropractors, such as neck pain, there are no additional overall costs.¹¹ As required by HB 1281, this study assesses the much broader subject of the full spectrum of conditions treated by chiropractors and physical therapists in the state of New Hampshire and analyzes both medical and

pharmacy administrative claims data in an effort to understand the relationships between use of chiropractic or physical therapy services and overall patient cost.

Methods

There are three major sections of the study: (1) evaluation of the relationship between copayment level for chiropractic and physical therapy services and use of these services, (2) evaluation of the relationship between copayment level and overall cost in patients who utilize chiropractic or physical therapy services, and (3) assessment of the relationship between use of chiropractic or physical therapy services and selected outcome measures. Each is discussed in turn below.

Relationship Between Copayment Level and Use of Chiropractic and PT Services

To evaluate the relationship between copayment level and the use of chiropractic or physical therapy services, Compass used a two-part model similar to the methodology used in the evaluation of chiropractic services in the RAND HIE. The first part of the model uses a logistic regression to predict the likelihood of using any services, and the second part of the model evaluates the cost of services given any use of services.

Compass constructed a patient-level dataset containing copayment level and cost variables for chiropractic care, physical therapy services, and overall medical and pharmacy. All cost variables were based on allowed cost (i.e., the sum of plan paid, copayment, coinsurance, and deductible amounts). The dataset was based on data from calendar year 2013 and was limited to patients who had continuous medical eligibility and continuous enrollment in a single copayment level throughout the year. To adjust for differences in patient health risk and cost levels, Compass also used CMS's publicly available HCC software to assign hierarchical condition categories (HCCs) to each patient in the dataset. These values were assigned concurrently (i.e., using 2013 medical claims data). Compass dropped from the final dataset any HCCs that occurred less frequently than once per ten thousand patients. Compass created a continuous age variable defined as 2013 minus the year of birth. The dataset also contained a variable indicating whether the patient had continuous pharmacy eligibility. Compass used this field to limit the dataset when analyzing overall (medical and pharmacy) cost.

The two-part model and specifically the transformation from nominal dollars to the natural log of dollars in the second part of the model are two very common but not the only economic approaches for handling health care cost data, which tend to be highly skewed and have a large portion of observations with a value of zero. Compass also set up a second model that used the generalized linear model technique with a Gamma distribution and log link proposed by Manning and Mullahy.¹² In general, Compass prefers this approach for modeling cost data, and both approaches yielded equivalent results in terms of directionality and statistical significance. However, there were instances of extremely high chiropractic cost outliers that appeared to be handled more accurately through the log of cost models. Rather than report on a truncated subset of the data that excluded outliers, Compass used the log of cost models for this section of the analysis.

The setup for the first part of the model was to use a logistic regression where the dependent variable was a binary variable indicating whether the patient used chiropractic or physical therapy services, and the independent variables were a categorical variable of copayment level, a binary gender variable (male), age, and the set of HCCs (set up as an array of binary variables indicating the presence of the condition), which served as a proxy for health status. Only HCCs that were statistically significant ($p < 0.05$) were kept in the model. Compass used this general process three times, once for the combination of chiropractic and physical therapy services, once for chiropractic services only, and once for physical therapy services only. The set of HCCs that were significant varied among these models.

For the purposes of reporting the results of part one of the model, Compass calculated the average predicted value for each level of copayment in the model. This was done by using the predicted values of each observation generated by the model and applying the effect of each copayment once per level of copayment, effectively generating a predicted value for each level of copayment on every observation in the dataset. After transforming the results to percentages, Compass calculated the mean for each level of copayment. Compass also reported the odds ratios given by the model.

The setup for the second part of the model was to use ordinary least squares (OLS) regression where the dependent variable was the natural log of cost, where cost was defined as the sum of chiropractic and physical therapy costs, and the independent variables were a categorical variable of copayment level, a binary gender variable (male), age, and the set of HCCs, which served as a proxy for health status. This model was limited to cases where the patient had any chiropractic or physical therapy services, so there were no cases of cost equal to zero. Only HCCs that were statistically significant ($p < 0.05$) were kept in the model. The final list of HCCs used in the second part of the two-part model did not have to be the same as the final list used in the first part. The other independent variables used were the same in both parts of the model. As in part one of the process, the second part of the model was estimated three times, once for both chiropractic and physical therapy services, once for chiropractic services, and once for physical therapy services, using the appropriate sample selection and cost criteria for each model run.

Because of concerns that the use of concurrent risk adjustment would “over-adjust” and wash out true variation, Compass ran an additional model without the HCC variables. The overall model fit was worse, but none of the estimates for the other independent variables materially changed.

In reporting results, Compass calculated Duan’s smearing estimator as described by Manning and Mullahy¹³ from the model residuals, then used that estimator to back-transform the results of the model from log dollars into the nominal dollar scale.

As additional confirmation, Compass also estimated a generalized linear model for the second part of the two-part model. The dataset and independent variables were the same, but the model used chiropractic and physical therapy cost in nominal dollars rather than the natural log of cost, and the model specified an underlying Gamma distribution with a log link. A modified Park test as described by Manning and Mullahy¹⁴ confirmed that Gamma was the most appropriate distribution. As described above, this approach had directionally similar results but appeared to be less robust to

the effect of the chiropractic cost outliers which caused the model to likely overstate the differences among copayment levels.

One additional approach that Compass explored was to attempt to directly measure the effect of changing copayment levels through longitudinal analysis. Compass created a similar patient-level dataset using data from calendar year 2012, then combined the 2012 and 2013 datasets and limited it to patients with continuous medical and pharmacy eligibility in both periods. This cut the sample size roughly in half. Unfortunately, the resulting sample of patients switching from low copayment to high copayment plans or vice versa was too small to produce reliable estimates.

Relationship Between Use of Chiropractic and PT Services and Overall Cost

Compass explored the possibility of directly measuring the relationship between chiropractic and physical therapy copayment level and overall costs in patients who utilize chiropractic or physical therapy services, but determined that direct model evaluation was infeasible due to the confounding factor of the general copayment level. From the RAND HIE it is likely that overall cost is affected by the general copayment level of the plan. Additionally, the chiropractic and physical therapy portion of the overall costs are affected by the copayment level for chiropractic and physical therapy services. Compass assigned both a general plan copayment level and a chiropractic and physical therapy specific copayment level and included both of these terms in early model attempts. However, this approach was discarded due to the presence of collinearity between the general copayment level and the chiropractic and physical therapy specific copayment level. The strong correlation between these two terms led to unreliable estimates when both were included in a regression model.

Instead Compass set up a model to evaluate the relationship between chiropractic and physical therapy costs and overall costs. The sample for this model was limited to patients who had chiropractic or physical therapy services. The model was a generalized linear model with a Gamma distribution and log-link and specified the overall cost (defined as the sum of medical and pharmacy costs) as the dependent variable. The independent variables were the general copayment level category, the sum of chiropractic and physical therapy cost, a binary gender variable (male), age, and the HCCs to adjust for patient health status. The first portion of this study established the relationship between chiropractic and physical therapy copayment level and use of chiropractic and physical therapy services. From the combination of the first portion of the study and this new model framework, the relationship between chiropractic and physical therapy copayment level and overall cost can be inferred. There is a correlation between the general copayment level and the amount of chiropractic and physical therapy services, but it is weaker than the correlation between the general copayment level and the chiropractic and physical therapy copayment level. Additionally, Compass ran models that alternately dropped general copayment level and chiropractic and physical therapy cost and found that the estimates on each of the terms remained stable, indicating that the collinearity was not strong enough to invalidate the estimated effects.

In addition to using overall cost, Compass ran a set of models using non-chiropractic, non-physical therapy costs (i.e., overall cost minus any chiropractic and physical therapy costs) as the dependent variable. These models used the same general setup as the models that used overall cost as the

dependent variable (i.e., generalized linear models with a Gamma distribution and log link and the same set of independent variables). This set of models was an attempt to detect any substitution effects of patients that utilize chiropractic or physical therapy services.

Compass ran both sets of models three times, once for chiropractic and physical therapy services, once for chiropractic services alone, and once for physical therapy services alone.

Similar to the methodology used in part two of the models analyzed in the first part of the study, Compass only kept HCCs that were statistically significant ($p < 0.05$) in the final set of models. The sets of HCCs used when analyzing models that varied by dependent variable and sample selection criteria (i.e., chiropractic and physical therapy services, chiropractic services, and physical therapy services) were different.

Compass also ran a set of models on a subset of the population sample that excluded the bottom 1% and top 1% of overall patients by overall cost. This was an attempt to mitigate the effect of outliers on the model estimates. These models used the same modeling technique, dependent variables, and independent variables as the models that were run on the full population.

Assessment of the Relationship Between Use of Chiropractic or PT Services and Selected Outcome Measures

Part of the proposed legislation states the need for consultation with providers regarding the scope of and issues relevant to the study. In addition, the legislation recognizes that information regarding patient outcomes is needed in addition to the above information about cost. One of the provider recommendations for a patient outcome that can be assessed using administrative claims data rather than more detailed clinical data was the relationship between chiropractic and physical therapy care and opioid use.

Using opioid classifications that Compass had previously developed, Compass constructed several opioid use variables: a binary variable indicating any opioid use, a binary variable indicating a total days supply of opioids greater than or equal to 30 days, a binary variable indicating a total days supply of opioids greater than or equal to 90 days, and the total days supply of opioids. These measures were then added to the patient level dataset.

During the initial model testing, Compass determined that the relationship between chiropractic care and opioid use was different than the relationship between physical therapy services and opioid use. This finding aligned with published research regarding these relationships.¹⁵ Because of this, Compass included separate terms for chiropractic care and physical therapy services in all of the models evaluating opioid use.

In an attempt to control for underlying differences in patient health status, Compass used presence of a given HCC as a method for limiting the sample size. First, Compass produced descriptive statistics on the prevalence of the HCCs in the patient sample as well as portions of patients with those HCCs that used chiropractic, physical therapy, or opioid services. See Appendix A for details. Next Compass, evaluated HCCs that showed indications of having a reasonably large sample size

and a comparatively large portion of patients with the HCC utilizing all three of the services of interest.

For each of the three binary response variables, Compass estimated two logistic models. Both sets of models used age and the binary variable male as independent variables but did not include any HCCs since the sample had already been limited to patients with a specified HCC. The other independent variables were either binary indicators for any use of chiropractic services and any use of physical therapy services or continuous variables of chiropractic cost and physical therapy cost.

Compass also estimated two models to evaluate the effect on the total days supply of opioids outcome variable. The first model was a generalized linear model with a Gamma distribution and log link that included age, the binary variable male, and binary variables for any use of chiropractic services and any use of physical therapy services as independent variables and used the total days supply as the dependent variable. The second model used a similar setup except for using continuous variables of chiropractic cost and physical therapy cost rather than binary variables indicating any use of services.

Data

The data source used in this study is the New Hampshire multi-payer claims database, the New Hampshire Comprehensive Health Care Information System (NH CHIS). The version of the NH CHIS data provided to Compass contains detailed claims and eligibility information for individuals with Commercial or Medicaid insurance from 2010 through 2013. For this study, Compass limited the sample to calendar year 2013. Compass did an initial data review to limit the data only to payers that did not have obviously incomplete data (i.e., payers with plausible PMPMs and no missing paid or incurred months). This included removing patients eligible for Medicaid or Medicare since there were limited Medicare claims in the dataset and the Medicaid claims were incomplete for 2013.

Due to known discrepancies in the coverage of medical behavioral health services across payers and plans as well as concerns about the completeness and reliability of the behavioral health indicator on the medical eligibility files, Compass excluded medical behavioral health payers and services (but not pharmacy claims) from the study.

Compass used the “person_key” field within the NH CHIS data as the unit of analysis. This field is the single ID that aggregates patients who have membership in multiple plans or across multiple payers.

Compass used the “group_id” field in the NH CHIS data to empirically assign copayment level. Investigation showed reasonably good consistency of copayment levels within a single group for a selected set of services. Compass summarized claim lines to the claim level and examined all groups for which there were at least 10 claims of interest in the period and then used the following methodology to assign copayment levels:

- Average copayment level of \$0 was assigned to ‘a) Zero Copay’

- Average copayment of greater than \$0 and up to \$10 was assigned to 'b) Low Copay'
- Average copayment of greater than \$10 and up to \$20 was assigned to 'c) Med Copay'
- Average copayment of greater than \$20 was assigned to 'd) High Copay'

Compass used this same method and criteria for assigning a 'Chiropractic and PT Copay Level' as well as a 'General Copay Level' which took into account all professional services.

As expected, there was a strong but not perfect correlation between Chiropractic and PT Copay Level and the General Copay level:

Crosstab of Chiro/PT Copay Level vs. General Copay Level:

		General Copay Level				Total	
		Zero	Low	Medium	High		
Chiropractic / PT Copay Level	Zero	36,111	26,359	4,120	937	67,527	22%
	Low	0	45,633	12,093	1,620	59,346	19%
	Medium	0	26,409	77,800	103	104,312	34%
	High	0	5,199	61,608	12,272	79,079	25%
	Total	36,111	103,600	155,621	14,932	310,264	
		12%	33%	50%	5%		

Compass assessed the chiropractic and physical therapy claims in the population of interest to determine how effective empirical assignment of the Chiropractic and PT Copay Level was. The results show that the copayment level assignment appears to be effective for the majority of claims and patients.

Evaluation of Copay on Chiropractic and PT Claims by Assigned Chiropractic and PT Copay Level

		N	Copay Mode	Copay Quartile1	Copay Median	Copay Quartile3	Copay Mean	Coins Mean	Deduct Mean
Chiropractic / PT Copay Level	Zero	49,329	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$3.80	\$27.97
	Low	96,011	\$0.00	\$0.00	\$0.00	\$5.00	\$4.60	\$1.64	\$4.14
	Medium	110,998	\$20.00	\$10.00	\$15.00	\$20.00	\$16.43	\$0.62	\$1.94
	High	60,815	\$50.00	\$25.00	\$38.39	\$50.00	\$38.57	\$0.32	\$1.82
	Total	317,153	\$0.00	\$0.00	\$10.00	\$20.00	\$14.54	\$1.36	\$14.54

It is important to note that the 'Zero Copay Level' is a combination of benefit plans that have no cost sharing and plans that use alternative methods of cost sharing, such as coinsurance or deductibles. The fields at the end of the table, 'Coins Mean' and 'Deduct Mean' show the average coinsurance and deductible levels on the set of chiropractic and physical therapy claims.

For risk adjustment, Compass downloaded and implemented mappings and logic for creating CMS's Hierarchical Condition Categories (HCCs).¹⁶ Compass used the primary diagnosis from the available medical claims data to assign binary flags for the HCCs at the patient level.

Results

Results for each of the three study areas are presented below.

Relationship Between Copayment Level and Use of Chiropractic and Physical Therapy Services

There is significant evidence that the use of chiropractic and physical therapy services was related to copayment level. The following table shows descriptive statistics based on unadjusted allowed cost.

Unadjusted Results of Chiropractic and PT Services

			N	% w/ Svcs	Mean Cost ¹	Mean Cost per Util Mbr ²	Median Cost per Util Mbr	Mean Cost per Util Mbr in 98% Subsample ³
Chiropractic or PT Services	Chiropractic / PT Copay Level	Zero	67,527	8.9%	\$53	\$600	\$379	\$585
		Low	59,346	16.9%	\$214	\$1,264	\$445	\$729
		Medium	104,312	12.9%	\$74	\$578	\$359	\$564
		High	79,079	10.2%	\$55	\$537	\$337	\$528
		Total	310,264	12.1%	\$92	\$756	\$381	\$603
Chiropractic Services	Chiropractic / PT Copay Level	Zero	67,527	5.6%	\$22	\$385	\$253	\$379
		Low	59,346	13.0%	\$156	\$1,205	\$338	\$540
		Medium	104,312	9.5%	\$35	\$371	\$263	\$368
		High	79,079	5.4%	\$26	\$365	\$238	\$361
		Total	310,264	8.7%	\$53	\$608	\$271	\$416
PT Services	Chiropractic / PT Copay Level	Zero	67,527	3.7%	\$32	\$856	\$619	\$822
		Low	59,346	5.1%	\$58	\$1,121	\$732	\$1,022
		Medium	104,312	4.1%	\$39	\$946	\$665	\$900
		High	79,079	3.6%	\$29	\$791	\$592	\$772
		Total	310,264	4.1%	\$38	\$936	\$657	\$885

¹Cost is defined as the allowed cost for the services specified in the first column (i.e., chiropractic and PT services, chiropractic services, PT services)

²Per Util Mbr means the total cost divided by the numbers of patients with any of the specified services

³The 98% subsample is a subset of the utilizing member dataset with the bottom 1% and top 1% of costs removed in order to mitigate the effect of outliers

Both chiropractic and physical therapy services show increased use of services with lower copayment levels. Because they display the same general pattern it is appropriate to pool them together in the analysis. The unadjusted data show that there are cost outliers in the use of chiropractic services within the low copayment level.

Compass used a two-part model to evaluate the relationship between Chiropractic and PT Copay Level and use of chiropractic and physical therapy services. The results show that there are statistically significant relationships between Chiropractic and PT Copay Level and the likelihood of using chiropractic or physical therapy services as well as between Chiropractic and PT Copay Level and the amount of chiropractic and physical therapy services used given any use of those services. Together, these results indicate that lower copayment levels on chiropractic and physical therapy services are related to higher use of these services.

After controlling for age, gender, and health status, the results for the first part of the model when analyzing the likelihood of patients having either chiropractic or physical therapy services is a statistically significant difference ($p < 0.0001$) between low and high copayment levels, with an odds ratio of 1.748 (95% Confidence Interval: 1.693 to 1.804).

The results for the first part of the model when analyzing chiropractic and physical therapy services separately are similar. Service use at low copayment levels is statistically significantly ($p < 0.0001$) higher in both cases, but the likelihood of receiving chiropractic services is more sensitive to copayment level (low copayment to high copayment odds ratio of 1.884 for chiropractic care and 1.389 for physical therapy services).

The following table shows the estimated results for each of the three sets of services by copayment level:

Estimated Likelihood of Using Services by Chiropractic/PT Copay Level

	Chiropractic or Physical Therapy Services	Chiropractic Services	Physical Therapy Services
Zero Copay	11.9%	5.6%	3.7%
Low Copay	16.6%	12.7%	5.1%
Medium Copay	13.0%	9.6%	4.2%
High Copay	8.8%	7.3%	3.6%

Similarly, after controlling for age, gender, and health status, the results for the second part of the model when analyzing the cost of chiropractic and physical therapy services among patients who had any chiropractic or physical therapy services show a statistically significant difference ($p < 0.0001$) between low and high copayment plans. Patients with any chiropractic or physical therapy costs in low copayment plans had estimated chiropractic and physical therapy costs nearly 40% higher than patients in high copayment plans (\$874 vs. \$628). As was the case in part one of

the model, there was a stronger relationship between the use of chiropractic care and copayment level than between physical therapy services and copayment level (\$706 vs. \$474, 52% higher in chiropractic and \$1,057 and \$820, 29% higher in physical therapy).

It is useful to note that the copayment level is not the only member cost sharing mechanism and that plans with zero copayment but evidence of alternative member cost sharing mechanisms displayed a lower likelihood of use of services but a higher use of services in cases where there was any service use. This is consistent with the results from the RAND HIE, which observed that there is a “blunting effect” around the effect of cost-sharing in the presence of a stop-loss limit as is common in high deductible plans.

Relationship Between Use of Chiropractic and Physical Therapy Services and Overall Cost

The analysis shows that the use of chiropractic services and the use of physical therapy services have different relationships with overall cost (defined in this analysis as the sum of pharmacy and non-behavioral health medical costs). For this section of the study, pooling chiropractic and physical therapy services is inappropriate.

Higher use of chiropractic services in patients with any chiropractic services is statistically significantly related ($p < 0.0001$) to higher overall cost after controlling for age, gender, health status, and plan design. Examination of the results showed that in general, adding \$1 of chiropractic costs resulted in less than \$1 in additional overall cost, indicating that the chiropractic services could be partially offsetting other services, which is consistent with the literature with regard to certain conditions commonly treated by chiropractors.¹⁷

When evaluating the relationship between the amount of use of chiropractic services used by patients who had any chiropractic care and the non-chiropractic costs of those patients, Compass found a small negative relationship ($p = 0.02$). This supports the previous result indicating that higher chiropractic costs are associated with higher overall costs but also with lower non-chiropractic costs.

Evaluation of the datasets that removed outliers produced directionally equivalent results although the result of the relationship between the amount of use of chiropractic services and non-chiropractic costs was less significant ($p = 0.17$).

Administrative claims data do not have the information necessary to support risk-adjusted analyses of the effect of physical therapy on overall cost. General health status adjustments from claims data without clinical information, such as functional status or severity indexes, do not accurately capture the underlying morbidity for the specific condition that led the patient to utilize physical therapy services. The HCCs were designed to capture a wide range of conditions that contribute to overall cost. The HCCs set up hierarchies within some conditions in order to account for increased severity of related illnesses, but not all of the conditions have these hierarchies and it's possible that more detailed clinical information than is available in administrative claims data would be needed in order to accurately assign severity levels to all conditions. For example, rheumatoid arthritis is a

single HCC but is a disease that tends to progress to other functional areas and result in joint damage over time, and costs per patient would be expected to have a wide range of severity within this category. Controlling for age, gender, and general health status the analysis finds that increased use of physical therapy services in patients with any physical therapy is statistically significantly related to both higher overall costs and higher non-physical therapy costs (both $p < 0.0001$). Examination of the results shows an increase of \$1 in physical therapy cost corresponds to an increase in overall cost far greater than \$1, and around \$3-\$4 in many of the observed results. An effect that large is much more likely to be related to unmeasured underlying morbidity for the condition being treated by physical therapy for which the model has not accounted than for an increase caused by the physical therapy services. Additionally, the general copayment level is not statistically significantly related to overall cost in patients who had any physical therapy services. Since the first stage of this analysis demonstrated that use of physical therapy services are related to copayment level, this suggests that there are underlying population characteristics that are washing out the other effects that the analysis is trying to detect.

Relationship Between Use of Chiropractic and PT Services and Outcomes

The literature contains numerous examples of studies demonstrating both positive patient outcomes and decreased likelihood of negative patient outcomes through the use of chiropractic and physical therapy services.^{18,19,20} This analysis focuses on the relationship between chiropractic and physical therapy services and opioid use. Again, it is necessary to analyze chiropractic care and physical therapy services separately.

The analysis examined four opioid use outcomes in patients with a diagnosis of rheumatoid arthritis: any opioid use, opioid use for 30+ days, opioid use for 90+ days, and the total days for patients who had any days of opioid use. In all four outcomes, either the use of chiropractic services or the amount of chiropractic services received was statistically significantly related to reductions in the outcomes of interest. The p-values ranged from < 0.0001 to 0.0153.

The use of physical therapy services and the amount of physical therapy services used were both statistically significantly related to an increased likelihood of any opioid use and long-term opioid use, with p-values ranging from < 0.0001 to 0.0111. There was no statistically significant relationship between either use of physical therapy services ($p = 0.96$) or the amount of physical therapy services ($p = 0.85$) used and the total days of opioid use in patients who had any opioid use.

The analysis uses a health status risk adjustment that is based only on administrative claims data and does not have access to clinical information. The analysis assumes homogeneity of severity/patient risk within patients with a diagnosis of rheumatoid arthritis, but the observed associations between chiropractic care and opioid use and physical therapy and opioid use could be the result of underlying population differences for which the analysis has not controlled.

Compass examined several other HCCs, but was only able to find any statistically significant effects in rheumatoid arthritis. The other HCCs generally showed similar directionality but were not statistically significant at the 0.05 level.

Additional Results

In order to validate the completeness of the data being evaluated, Compass empirically derived the 50 most common primary ICD 9 diagnoses treated by chiropractors or physical therapists and then tabulated the percent of patients in the sample who had those diagnoses during calendar year 2013. The results are found in Appendix B.

Conclusions

The results of the study show that there is a negative and statistically significant relationship between the copayment level and the use of chiropractic care or physical therapy services. The analysis shows that lower copayment levels are associated with both increased likelihood of using the services and increased amount of services used for patients with any service use. This is true for both chiropractic care and physical therapy services and is true after controlling for age, gender, and health status.

The study also shows that an increase in either chiropractic care costs or an increase in physical therapy costs are statistically significantly related to increases in overall costs. For chiropractic care costs, there is evidence that chiropractic care has partial substitution effects for medical services. There is strong evidence that risk adjustment using information not available through administrative claims data is needed in order to determine if physical therapy costs offset other medical or pharmacy costs.

Similarly, the outcome measures evaluated in this study may require additional risk adjustment. There is evidence that increased use of chiropractic care is associated with lower opioid use and that increased use of physical therapy services is associated with increased opioid use, but it is unclear whether these differences are due to underlying differences in patient severity.

Overall, in the commercially insured population in New Hampshire, lower copayment levels for chiropractic and physical therapy services are associated with increased likelihood of using and increased amount of use of those services as well as higher overall patient costs. Through the evaluation of the 'zero copay' plans, there is evidence that cost sharing through mechanisms such as coinsurance and deductibles to some extent behave similarly.

It is important to note that although this analysis shows a relationship between lower copayment for chiropractic and physical therapy services and increased use of and cost of both these services and overall medical and pharmacy costs, it is a cross-sectional study that shows correlation not causation. There could be selection bias effects (i.e., patients more likely to use services self-select into plans with lower copayment levels). This study also only analyzes direct costs, and does not consider other societal benefits such as reduced worker absenteeism. Finally, the value proposition for medical services needs to consider costs, both direct and indirect, but also quality, patient outcomes, and patient satisfaction. The research literature supports significant patient outcome benefits and patient satisfaction in use of both chiropractic and physical therapy services.

Appendix A

HCC Description	Patients	Patient %	PT Users	PT %	Chiro Users	Chiro %	Opioid Users	Opioid %	PT w/in HCC %	Chiro w/in HCC %	Opioid w/in HCC %
1 HIV/AIDS	146	0.0%	6	0.0%	10	0.0%	38	0.1%	4.1%	6.8%	26.0%
2 Septicemia/Shock	319	0.1%	27	0.2%	24	0.1%	190	0.4%	8.5%	7.5%	59.6%
5 Opportunistic Infections	68	0.0%	10	0.1%	9	0.0%	31	0.1%	14.7%	13.2%	45.6%
7 Metastatic Cancer and Acute Leukemia	512	0.2%	32	0.3%	40	0.1%	306	0.6%	6.3%	7.8%	59.8%
8 Lung, Upper Digestive Tract, and Other Severe Cancers	276	0.1%	15	0.1%	28	0.1%	135	0.3%	5.4%	10.1%	48.9%
9 Lymphatic, Head and Neck, Brain, and Other Major Cancers	1,097	0.4%	68	0.5%	120	0.4%	380	0.7%	6.2%	10.9%	34.6%
10 Breast, Prostate, Colorectal and Other Cancers and Tumors	4,592	1.5%	297	2.3%	576	2.1%	1,523	3.0%	6.5%	12.5%	33.2%
15 Diabetes with Renal Manifestation	494	0.2%	27	0.2%	46	0.2%	182	0.4%	5.5%	9.3%	36.8%
16 Diabetes with Neurologic or Peripheral Circulatory Manifestation	858	0.3%	63	0.5%	95	0.4%	333	0.7%	7.3%	11.1%	38.8%
17 Diabetes with Acute Complications	191	0.1%	9	0.1%	14	0.1%	55	0.1%	4.7%	7.3%	28.8%
18 Diabetes with Ophthalmologic Manifestation	708	0.2%	41	0.3%	74	0.3%	195	0.4%	5.8%	10.5%	27.5%
19 Diabetes with No or Unspecified Complications	9,891	3.2%	527	4.1%	1,044	3.8%	2,750	5.4%	5.3%	10.6%	27.8%
21 Protein-Calorie Malnutrition	168	0.1%	15	0.1%	21	0.1%	63	0.1%	8.9%	12.5%	37.5%
25 End-Stage Liver Disease	96	0.0%	5	0.0%	5	0.0%	46	0.1%	5.2%	5.2%	47.9%
26 Cirrhosis of Liver	237	0.1%	4	0.0%	25	0.1%	95	0.2%	1.7%	10.5%	40.1%
27 Chronic Hepatitis	271	0.1%	20	0.2%	24	0.1%	84	0.2%	7.4%	8.9%	31.0%
31 Intestinal Obstruction/Perforation	514	0.2%	40	0.3%	51	0.2%	310	0.6%	7.8%	9.9%	60.3%
32 Pancreatic Disease	1,124	0.4%	98	0.8%	153	0.6%	477	0.9%	8.7%	13.6%	42.4%
33 Inflammatory Bowel Disease	1,614	0.5%	94	0.7%	196	0.7%	525	1.0%	5.8%	12.1%	32.5%
37 Bone/Joint/Muscle Infections/Necrosis	374	0.1%	69	0.5%	52	0.2%	227	0.4%	18.4%	13.9%	60.7%
38 Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	2,940	0.9%	336	2.6%	499	1.8%	1,176	2.3%	11.4%	17.0%	40.0%
44 Severe Hematological Disorders	98	0.0%	7	0.1%	10	0.0%	33	0.1%	7.1%	10.2%	33.7%
45 Disorders of Immunity	1,267	0.4%	110	0.9%	195	0.7%	491	1.0%	8.7%	15.4%	38.8%
51 Drug/Alcohol Psychosis	306	0.1%	17	0.1%	29	0.1%	120	0.2%	5.6%	9.5%	39.2%
52 Drug/Alcohol Dependence	1,428	0.5%	64	0.5%	120	0.4%	810	1.6%	4.5%	8.4%	56.7%
54 Schizophrenia	163	0.1%	6	0.0%	4	0.0%	35	0.1%	3.7%	2.5%	21.5%
55 Major Depressive, Bipolar, and Paranoid Disorders	9,319	3.0%	677	5.3%	1,267	4.7%	2,789	5.5%	7.3%	13.6%	29.9%
67 Quadriplegia, Other Extensive Paralysis	76	0.0%	13	0.1%	6	0.0%	21	0.0%	17.1%	7.9%	27.6%
68 Paraplegia	47	0.0%	11	0.1%	1	0.0%	22	0.0%	23.4%	2.1%	46.8%
69 Spinal Cord Disorders/Injuries	336	0.1%	56	0.4%	41	0.2%	139	0.3%	16.7%	12.2%	41.4%
70 Muscular Dystrophy	59	0.0%	8	0.1%	2	0.0%	12	0.0%	13.6%	3.4%	20.3%
71 Polyneuropathy	962	0.3%	134	1.1%	134	0.5%	434	0.9%	13.9%	13.9%	45.1%
72 Multiple Sclerosis	713	0.2%	65	0.5%	84	0.3%	204	0.4%	9.1%	11.8%	28.4%
73 Parkinson's and Huntington's Diseases	109	0.0%	13	0.1%	10	0.0%	31	0.1%	11.9%	9.2%	28.6%
74 Seizure Disorders and Convulsions	1,789	0.6%	118	0.9%	173	0.6%	426	0.8%	6.6%	9.7%	23.8%
75 Seizure Disorders and Convulsions	95	0.0%	9	0.1%	9	0.0%	31	0.1%	9.5%	9.5%	32.6%
79 Cardio-Respiratory Failure and Shock	625	0.2%	56	0.4%	63	0.2%	306	0.6%	9.0%	10.1%	49.0%
80 Congestive Heart Failure	1,139	0.4%	70	0.6%	102	0.4%	433	0.9%	6.1%	9.0%	38.0%
81 Acute Myocardial Infarction	257	0.1%	12	0.1%	24	0.1%	85	0.2%	4.7%	9.3%	33.1%
82 Unstable Angina and Other Acute Ischemic Heart Disease	249	0.1%	19	0.1%	22	0.1%	104	0.2%	7.6%	8.8%	41.8%
83 Angina Pectoris/Old Myocardial Infarction	315	0.1%	21	0.2%	37	0.1%	94	0.2%	6.7%	11.7%	29.8%
92 Specified Heart Arrhythmias	2,312	0.7%	177	1.4%	246	0.9%	718	1.4%	7.7%	10.6%	31.1%
95 Cerebral Hemorrhage	148	0.0%	14	0.1%	18	0.1%	68	0.1%	9.5%	12.2%	45.9%
96 Ischemic or Unspecified Stroke	406	0.1%	37	0.3%	35	0.1%	146	0.3%	9.1%	8.6%	36.0%
100 Hemiplegia/Hemiparesis	113	0.0%	14	0.1%	14	0.1%	31	0.1%	12.4%	12.4%	27.4%
101 Diplegia (Upper), Monoplegia, and Other Paralytic Syndromes	96	0.0%	21	0.2%	9	0.0%	21	0.0%	21.9%	9.4%	21.9%
104 Vascular Disease with Complications	625	0.2%	59	0.5%	51	0.2%	299	0.6%	9.4%	8.2%	47.8%
105 Vascular Disease	1,673	0.5%	135	1.1%	170	0.6%	708	1.4%	8.1%	10.2%	42.3%
107 Cystic Fibrosis	57	0.0%	7	0.1%	5	0.0%	10	0.0%	12.3%	8.8%	17.5%
108 Chronic Obstructive Pulmonary Disease	1,898	0.6%	115	0.9%	189	0.7%	796	1.6%	6.1%	10.0%	41.9%
111 Aspiration and Specified Bacterial Pneumonias	94	0.0%	10	0.1%	11	0.0%	39	0.1%	10.6%	11.7%	41.5%
112 Pneumococcal Pneumonia, Empyema, Lung Abscess	119	0.0%	9	0.1%	14	0.1%	48	0.1%	7.6%	11.8%	40.3%
119 Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	188	0.1%	10	0.1%	10	0.0%	58	0.1%	5.3%	5.3%	30.9%
131 Renal Failure	958	0.3%	56	0.4%	84	0.3%	372	0.7%	5.8%	8.8%	38.8%
132 Nephritis	103	0.0%	2	0.0%	13	0.0%	31	0.1%	1.9%	12.6%	30.1%
148 Decubitus Ulcer of Skin	75	0.0%	9	0.1%	2	0.0%	40	0.1%	12.0%	2.7%	53.3%
149 Chronic Ulcer of Skin, Except Decubitus	446	0.1%	44	0.3%	43	0.2%	197	0.4%	9.9%	9.6%	44.2%
155 Major Head Injury	468	0.2%	46	0.4%	59	0.2%	205	0.4%	9.8%	12.6%	43.8%
157 Vertebral Fractures	334	0.1%	60	0.5%	38	0.1%	191	0.4%	18.0%	11.4%	57.2%
158 Hip Fracture/Dislocation	255	0.1%	60	0.5%	24	0.1%	144	0.3%	23.5%	9.4%	56.5%
161 Traumatic Amputation	64	0.0%	7	0.1%	11	0.0%	33	0.1%	10.9%	17.2%	51.6%
164 Major Complications of Medical Care and Trauma	1,384	0.4%	251	2.0%	158	0.6%	891	1.8%	18.1%	11.4%	64.4%
174 Major Organ Transplant Status	100	0.0%	5	0.0%	10	0.0%	37	0.1%	5.0%	10.0%	37.0%
176 Artificial Openings for Feeding or Elimination	391	0.1%	25	0.2%	35	0.1%	198	0.4%	6.4%	9.0%	50.6%

Appendix B

Code	Description	Patients w/ Diagnosis	% of Patients w/ Diagnosis
739.1	NONALLOPATHIC LESIONS OF CERVICAL REGION NOT ELSEWHERE CLASSIFIED	5,383	1.8%
724.2	LUMBAGO	12,027	3.9%
739.3	NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED	3,961	1.3%
723.1	CERVICALGIA	9,266	3.0%
719.46	PAIN IN JOINT INVOLVING LOWER LEG	10,937	3.6%
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	7,800	2.5%
739.2	NONALLOPATHIC LESIONS OF THORACIC REGION NOT ELSEWHERE CLASSIFIED	2,032	0.7%
847.0	SPRAIN OF NECK	2,894	0.9%
839.20	CLOSED DISLOCATION LUMBAR VERTEBRA	1,589	0.5%
839.08	CLOSED DISLOCATION MULTIPLE CERVICAL VERTEBRAE	1,471	0.5%
847.2	SPRAIN LUMBAR REGION	2,451	0.8%
739.4	NONALLOPATHIC LESIONS OF SACRAL REGION NOT ELSEWHERE CLASSIFIED	1,200	0.4%
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH	4,539	1.5%
724.1	PAIN IN THORACIC SPINE	2,369	0.8%
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED	3,058	1.0%
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY	2,720	0.9%
726.10	DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION UNSPECIFIED	2,486	0.8%
724.5	BACKACHE UNSPECIFIED	7,393	2.4%
719.47	PAIN IN JOINT INVOLVING ANKLE AND FOOT	5,407	1.8%
846.0	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN	991	0.3%
724.3	SCIATICA	1,837	0.6%
723.4	BRACHIAL NEURITIS OR RADICULITIS NOT OTHERWISE SPECIFIED	1,869	0.6%
739.5	NONALLOPATHIC LESIONS OF PELVIC REGION NOT ELSEWHERE CLASSIFIED	431	0.1%
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC	3,243	1.1%
847.1	SPRAIN THORACIC REGION	1,056	0.3%
726.2	OTHER AFFECTIONS OF SHOULDER REGION NOT ELSEWHERE CLASSIFIED	1,427	0.5%
728.71	PLANTAR FASCIAL FIBROMATOSIS	2,488	0.8%
715.16	OSTEOARTHROSIS LOCALIZED PRIMARY INVOLVING LOWER LEG	2,265	0.7%
726.71	ACHILLES BURSITIS OR TENDINITIS	903	0.3%
723.3	CERVICOBRACHIAL SYNDROME (DIFFUSE)	419	0.1%
839.42	CLOSED DISLOCATION SACRUM	529	0.2%
840.4	ROTATOR CUFF (CAPSULE) SPRAIN	1,006	0.3%
844.2	SPRAIN OF CRUCIATE LIGAMENT OF KNEE	707	0.2%
727.61	COMPLETE RUPTURE OF ROTATOR CUFF	525	0.2%
726.0	ADHESIVE CAPSULITIS OF SHOULDER	721	0.2%
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY	1,726	0.6%
724.6	DISORDERS OF SACRUM	765	0.2%
839.00	CLOSED DISLOCATION CERVICAL VERTEBRA UNSPECIFIED	306	0.1%
781.2	ABNORMALITY OF GAIT	593	0.2%
719.7	DIFFICULTY IN WALKING	165	0.1%
839.21	CLOSED DISLOCATION THORACIC VERTEBRA	569	0.2%
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY	1,117	0.4%
726.5	ENTHESOPATHY OF HIP REGION	1,347	0.4%
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC	1,726	0.6%
845.00	UNSPECIFIED SITE OF ANKLE SPRAIN	2,761	0.9%
739.0	NONALLOPATHIC LESIONS OF HEAD REGION NOT ELSEWHERE CLASSIFIED	319	0.1%
V43.65	KNEE JOINT REPLACEMENT	496	0.2%
729.1	MYALGIA AND MYOSITIS UNSPECIFIED	2,915	0.9%
717.7	CHONDROMALACIA OF PATELLA	962	0.3%
726.32	LATERAL EPICONDYLITIS ELBOW REGION	1,464	0.5%

Endnotes

¹Brook I. Martin, Mary M. Gerkovich, Richard A. Deyo, Karen J. Sherman, Daniel C. Cherkin, Bonnie K. Lind, Christine M. Goertz, William E. Lafferty. The Association of Complementary and Alternative Medicine Use and Health Care Expenditures for Back and Neck Problems. *Med Care*. 2012 December ; 50(12): 1029–1036.

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- ¹² Manning, Willard G., and John Mullahy. Estimating log models: to transform or not to transform?. *Journal of health economics* 20.4 (2001): 461-494.
- ¹³ Manning, Willard G., and John Mullahy. Estimating log models: to transform or not to transform?. *Journal of health economics* 20.4 (2001): 461-494.
- ¹⁴ Manning, Willard G., and John Mullahy. Estimating log models: to transform or not to transform?. *Journal of health economics* 20.4 (2001): 461-494.
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Archived: Thursday, May 19, 2022 12:44:33 PM
From: Heaton, Michelle
Sent: Thursday, February 3, 2022 8:11:33 AM
To: ~House Commerce Committee
Cc: Mobley, Martha V
Subject: HB 1245 relative to copayments for services rendered by a chiropractor
Importance: Normal

Dear Commerce and Consumer Affairs Committee Members,

Thank you for the opportunity to testify yesterday at the hearing on HB 1245 relative to copayments for services rendered by a chiropractor. As I mentioned yesterday, the Insurance Department was previously tasked with studying this issue and issued two reports were issued in 2015 and 2018. The reports are available on the Department's website at [New Hampshire Insurance Department - Reports \(nh.gov\)](https://www.nh.gov/insurance). I have also attached both reports for your convenience.

Best,

Michelle Heaton, Esq.
Health Law and Policy Legal Counsel
NH Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

Telephone: (603) 271-2399
Fax: (603) 271-1406
Email: michelle.c.heaton@ins.nh.gov

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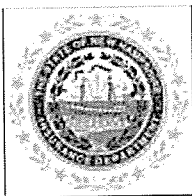
Contact our Consumer Services Division with questions or complaints at (800) 852-3416 or

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Archived: Tuesday, April 5, 2022 2:37:44 PM
From: mhstagnone@comcast.net
Sent: Monday, February 14, 2022 7:18:07 PM
To: ~House Commerce Committee
Subject: HB1245 supplement to testimony
Importance: Normal

Dear Representative,

I am writing you as a supplement to my testimony before your Committee on February 2nd regarding insurance co payments for Chiropractic services, HB1245. As is typical I'm sure, there were elements I wish we had discussed which may have proven helpful. Please consider the following as you discuss further this legislation and the impact upon the people we all serve.

- We consider this bill to be one that protects consumers from unfair business practices. "The use of deceptive, fraudulent, or otherwise unethical methods to gain an advantage or turn a profit" is by definition under of the Federal Trade Commission an act of unfair trade. The act of allowing an insurer to market and sell Chiropractic services while simultaneously setting parameters around those services such that the insurer never incurs an expense appears to fit the above definition. In the past we have used catchy terms such as "phantom benefit" to describe these practices when in fact it's just plain wrong. I would hope that this is the only argument in favor of this legislation we would need to make, however, for over fifteen years we have tried to correct this injustice upon New Hampshire consumers without relief.
- With regular consistency the New Hampshire Insurance Dept. has taken a "no position" on this legislation and back that position with testimony often including dialog on "cost sharing" studies as they did once again on February 2nd in mentioning the "Compass" study commissioned by the State of New Hampshire. What is often failed to be mentioned is that in this report, specifically on page 10, are the findings that for every dollar spent on Chiropractic services, less than one dollar in expense is incurred. When combined with other parts of the report citing superior patient satisfaction and a reduction in opioid use, it has always been puzzling as to why the insurance department would take such a position. Never am I able to recall in years of testimony, including most recently, has there ever been presented a cost analysis to the contrary.
- With opioid overdoses for January of 2022 at a three year high in the cities of Nashua and Manchester, the New Hampshire legislature, regardless of committee, should be giving exceptional attention to any authentic methods of reducing opioid utilization. The Dartmouth study of 13,000 New Hampshire insured residents for the years 2012 and 2013 demonstrated a 55% reduction in prescribing an opioid when Chiropractic care was an accessible benefit to the insured. There are numerous other studies around the nation demonstrating similar outcomes. Permitting an insurer to selectively target the Chiropractic consumer with an excessively high co payment is not only an unfair act of trade, in this case it places the consumer at a higher risk of addiction as they pursue the less expensive pharmaceutically based methods of care out of no desire of their own.

It is my deep and sincere hope that this time the Commerce Committee will recognize the long standing injustice to the New Hampshire consumer and the Chiropractic profession

in allowing these practices to continue. I respectfully encourage you to vote in favor of HB1245.

Sincerely,
Mark W. Stagnone, D.C.
Immediate Past President, New Hampshire Chiropractic Association
50 Nashua Rd. STE 106
Londonderry, NH 03053
603.434.1236

Carrie Morris

From: Janelle Bard <bardj11@yahoo.com>
Sent: Tuesday, February 22, 2022 11:49 AM
To: ~House Commerce Committee
Subject: Support HB 1245

Dear Chairman Hunt and members of the House Commerce and Consumr Affairs Committee,

My name is Dr. Janelle Bard, chiropractor and I work in Lincoln, NH. I am writing today to strongly encourage you to support HB1245, which would require that co-payments for the services of a chiropractor shall not be greater than those charged for a primary care physician or an osteopath.

For decades chiropractors are classified as "specialist" and are dealing with excessive co-pays. Chiropractors DO NOT practice like specialists, nor are they reimbursed like them. This is leading to unfair financial burden's on patients. Patients are told their insurance plans cover chiropractic, only to later learn their co-pay exceeds the actual cost of a treatment; making their ins. useless.

Please stop this and treat us on equal level as other doctors.

Thank you for your time and consideration. I urge you to support HB 1245, for the sake of patients needing our care.

Very truly yours,

Janelle L. Bard, D.C.

Dr. Janelle L. Bard
POBox 688
Lincoln, NH 03251
(603)745-2777
DrJanelleBard.com

Carrie Morris

From: mhstagnone@comcast.net
Sent: Sunday, February 20, 2022 7:01 PM
To: ~House Commerce Committee
Subject: HB1245finalcomments

Dear Representative,

It has come to my attention that the Committee is likely to vote on HB1245 this week. Representative Lundgren has shared with me a couple concerns expressed to him via Chairman Hunt. Please allow me to address these concerns.

Chairman Hunt has indicated some level of satisfaction relative to the 12 visit minimum required by New Hampshire law for chiropractic services. He brought this up in conversation with me following my testimony on February 2nd as well. This legislation was passed approximately 15-20 years ago in relation to the medical gatekeeper referral requirement some insurance companies were placing on chiropractic benefits. It was yet another highly effective strategy at limiting the patient's ability to access their chiropractic benefits. As part of the agreement to remove this requirement the 12 visit minimum, modeled after Medicare benefits at the time, was adopted. As some of you may have already calculated, it does not matter what number of visits a patient is allowed if the "specialist" co payment requires they cover the entirety of their care. Some of these "specialist" policies come into our offices with "unlimited" visits. It doesn't matter, the patient experiences no benefit.

Additionally is a concern that other providers, specifically Physical Therapists, will want to jump on board this legislation. Approximately four or five years ago the New Hampshire Chiropractic Association actually pursued similar legislation in conjunction with the Physical Therapists. We learned several things as a result of that experience. First, billing and compensation for the two professions is handled quite differently. P.T.'s are allowed the use of a much broader number of treatment codes in a cumulative fashion enabling a single session to easily exceed \$100 and more. Chiropractors are not extended the same benefit whereas we are limited to manipulation only by most insurers. This likely accounts for the findings of the Compass Study commissioned by the State of New Hampshire at the time which found that while Chiropractic services reduced overall expense, P.T. utilization actually resulted in increased costs. The Compass Study also found that while opioid use declined when Chiropractic was included, opioid utilization was more likely with Physical Therapy. It has recently come to our attention that numerous Veterans Hospitals are now encouraging the Chiropractor as the initial patient contact for these and other reasons. The citizens of our state deserve similar access to their benefits.

Thank you again for your consideration,

Mark W. Stagnone, D.C.
Immediate Past President, New Hampshire Chiropractic Association
50 Nashua Rd. STE 106
Londonderry, NH 03053
603.434.1236

Carrie Morris

From: mhstagnone@comcast.net
Sent: Monday, February 14, 2022 7:18 PM
To: ~House Commerce Committee
Subject: HB1245 supplement to testimony

Dear Representative,

I am writing you as a supplement to my testimony before your Committee on February 2nd regarding insurance co payments for Chiropractic services, HB1245. As is typical I'm sure, there were elements I wish we had discussed which may have proven helpful. Please consider the following as you discuss further this legislation and the impact upon the people we all serve.

- We consider this bill to be one that protects consumers from unfair business practices. "The use of deceptive, fraudulent, or otherwise unethical methods to gain an advantage or turn a profit" is by definition under of the Federal Trade Commission an act of unfair trade. The act of allowing an insurer to market and sell Chiropractic services while simultaneously setting parameters around those services such that the insurer never incurs an expense appears to fit the above definition. In the past we have used catchy terms such as "phantom benefit" to describe these practices when in fact it's just plain wrong. I would hope that this is the only argument in favor of this legislation we would need to make, however, for over fifteen years we have tried to correct this injustice upon New Hampshire consumers without relief.
- With regular consistency the New Hampshire Insurance Dept. has taken a "no position" on this legislation and back that position with testimony often including dialog on "cost sharing" studies as they did once again on February 2nd in mentioning the "Compass" study commissioned by the State of New Hampshire. What is often failed to be mentioned is that in this report, specifically on page 10, are the findings that for every dollar spent on Chiropractic services, less than one dollar in expense is incurred. When combined with other parts of the report citing superior patient satisfaction and a reduction in opioid use, it has always been puzzling as to why the insurance department would take such a position. Never am I able to recall in years of testimony, including most recently, has there ever been presented a cost analysis to the contrary.
- With opioid overdoses for January of 2022 at a three year high in the cities of Nashua and Manchester, the New Hampshire legislature, regardless of committee, should be giving exceptional attention to any authentic methods of reducing opioid utilization. The Dartmouth study of 13,000 New Hampshire insured residents for the years 2012 and 2013 demonstrated a 55% reduction in prescribing an opioid when Chiropractic care was an accessible benefit to the insured. There are numerous other studies around the nation demonstrating similar outcomes. Permitting an insurer to selectively target the Chiropractic consumer with an excessively high co payment is not only an unfair act of trade, in this case it places the consumer at a higher risk of addiction as they pursue the less expensive pharmaceutically based methods of care out of no desire of their own.

It is my deep and sincere hope that this time the Commerce Committee will recognize the long standing injustice to the New Hampshire consumer and the Chiropractic profession in allowing these practices to continue. I respectfully encourage you to vote in favor of HB1245.

Sincerely,
Mark W. Stagnone, D.C.

HB1245-FN

Bill Details

Title: relative to copayments for services rendered by a chiropractor.

Sponsors: *(Prime)* Lundgren (R), Dolan (R), Love (R)

LSR Number: 22-2621

General Status: HOUSE

House:

Committee: Commerce and Consumer Affairs

Due Out: 3/10/2022

Status: INTERIM STUDY

HB 1245-FN - AS INTRODUCED

2022 SESSION

22-2621

05/11

HOUSE BILL *1245-FN*

AN ACT relative to copayments for services rendered by a chiropractor.

SPONSORS: Rep. Lundgren, Rock. 5; Rep. Dolan, Rock. 5; Rep. Love, Rock. 6

COMMITTEE: Commerce and Consumer Affairs

ANALYSIS

This bill provides that copayments for the services of a chiropractor shall not be greater than those charged for a primary care physician or an osteopath.

Explanation: Matter added to current law appears in *bold italics*.
Matter removed from current law appears ~~in brackets and struck through~~.
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.
22-2621
05/11

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Two

AN ACT relative to copayments for services rendered by a chiropractor.

Be it Enacted by the Senate and House of Representatives in General Court convened:

- 1 New Section; Insurance; Individual; Copayments for Chiropractic Services. Amend RSA 415 by inserting after section 6-a1 the following new section:
415:6-bb Copayments, Coinsurance, or Office Visit Deductible for Chiropractic Services. Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance that constitutes health coverage for the services chiropractors licensed under RSA 316-A shall not charge a copayment, coinsurance, or office visit deductible that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for the services of a primary care physician or an osteopath licensed under RSA 329 for an office visit.
- 2 New Section; Insurance; Group; Copayments for Chiropractic Services. Amend RSA 415 by inserting after section 18-ee the following new section:
415:18-ff Copayments, Coinsurance, or Office Visit Deductible for Chiropractic Services. Each insurer that issues or renews any policy of group or blanket accident or health insurance that constitutes health coverage for the services of chiropractors licensed under RSA 316-A shall not charge a copayment, coinsurance, or office visit deductible that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for the services of a primary care physician or an osteopath licensed under RSA 329 for an office visit.
- 3 Health Service Corporations; Copayments for Chiropractic Services. Amend 420-A:2 to read as follows:
420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6, II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:6-y, RSA 415:6-z, *RSA 415:6-bb*, RSA 415:6-a1, RSA 415:18, V, RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-i, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:18-cc, RSA 415:18-dd, RSA 415:18-ee, *RSA 415:18-ff*, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable provisions of title XXXVII wherein such corporations are specifically included. Every health service corporation and its agents shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.
- 4 Health Maintenance Corporations; Copayments for Chiropractic Services. Amend RSA 420-B:20, III to read as follows:
III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g, RSA 415:6-m, RSA 415:6-o, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:6-y, RSA 415:6-z, *RSA 415:6-bb*, RSA 415:6-a1, RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, RSA 415:18-j, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:18-cc, RSA 415:18-dd, RSA 415:18-ee, *RSA 415:18-ff*, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.
- 5 Effective Date. This act shall take effect 60 days after its passage.

LBA

22-2621

10/28/21

**HB 1245-FN- FISCAL NOTE
AS INTRODUCED**

AN ACT relative to copayments for services rendered by a chiropractor.

FISCAL IMPACT: State County Local None

STATE:	Estimated Increase / (Decrease)			
	FY 2022	FY 2023	FY 2024	FY 2025
Appropriation	\$0	\$0	\$0	\$0
Revenue	\$0	Indeterminable	Indeterminable	Indeterminable
Expenditures	\$0	\$0	\$0	\$0
Funding Source:	<input checked="" type="checkbox"/> General	<input type="checkbox"/> Education	<input type="checkbox"/> Highway	<input type="checkbox"/> Other

COUNTY:

Revenue	\$0	\$0	\$0	\$0
Expenditures	\$0	Indeterminable	Indeterminable	Indeterminable

LOCAL:

Revenue	\$0	\$0	\$0	\$0
Expenditures	\$0	Indeterminable	Indeterminable	Indeterminable

METHODOLOGY:

This bill provides that copayments for the services of a chiropractor shall not be greater than those charged for a primary care physician or an osteopath.

The Insurance Department states, to the extent policies are in place today that utilize higher copays and deductibles for chiropractic services, such a change would place inflationary pressure on claim costs. Issuers would be responsible for a greater share of the cost of service and there may be increased utilization for such services with reduced cost sharing obligations. Issuers and insurance purchasers may respond by absorbing these pressures through increased premiums or by purchasing reduced coverages. The State collects premium tax on insurance premiums. The Department indicates it is unclear what, if any, impact this bill would have on premium tax revenues.

The Department of Administrative Services indicates this bill would have no impact on State health insurance expenditures because the State Health Benefit Plan for Employees and Retirees (the Plan) is a governmental self-insured plan that is not subject to insurance or managed care law. In addition, the current plan design already covers chiropractic services at the same level as a primary care physician office visit.

It is assumed that any fiscal impact would occur after FY 2022.

AGENCIES CONTACTED:

Departments of Insurance and Administrative Services