MEMORANDUM

TO: **DISTRIBUTION**

FROM: **COLORADO COMMISSION ON AFFORDABLE HEALTH CARE**

DATE: **NOVEMBER 30, 2015**

SUBJ; **HB15-1083; PHYSICAL REHABILITATION SERVICES-COPAYMENTS AND COINSURANCE, RESEARCH**

The Colorado Commission on Affordable Health Care was directed to provide a report on the effect of copays and coinsurance on the use of rehabilitation services to the General Assembly by November 1, 2015. That was accomplished but subsequently, requests for clarification have been made to the Commission.

For this analysis, Milliman, a health care actuarial firm, and consultant, was engaged by the Commission. They were given a copy of the subject legislation, some background on the questions being posed, including a similar study performed by another group, and further details on specific data that might help inform policy makers regarding this subject.

For its analysis, Milliman drew upon statistical data found in the Truven Health Analytics MarketScan report. This report contains commercial claims and membership data from 2013 for persons with continuous enrollment. This data resource was used because it is an accepted resource that provides a significant amount of Colorado specific data.

Milliman's report provided the following observations (all quoted references are from that report):

- ***What is the impact of copayments and cost sharing on utilization?***
  "Higher levels of copays or other cost-sharing often leads to lower utilization of services." Similar conclusions have been made by multiple studies over the past twenty years.

  "It is clear, however, that insured members use more rehabilitation services as cost-sharing is reduced, and less rehabilitation service as cost-sharing is increased."

- ***What is the cost effectiveness of therapy versus other options for care?***
  The data provided by Milliman demonstrates that the cost of a visit for the various therapy options is lower than that of a traditional physician office visit. The Commission noted from the data that the actual copay amount may be higher than that of a traditional physician office visit in some benefit plans, and that the percentage of cost sharing per visit may also be higher for a theraphy visit than for a traditional physician office visit.

  That is not to say that a therapy visit can substitute for a physician office visit. The place for such therapy is typically after a sound diagnosis has been rendered. In some instances a straight forward diagnosis can be provided by the therapist. Yet, in others a physician's assessment is necessary before therapy begins. One type of visit does not

necessarily supplant the need for the other. Facts and circumstances must prevail in making this assessment.

- ***Does cost sharing create a barrier to effective care?***
  It could not be determined from the data whether patient cost sharing "creates barriers to the effective use of physical rehabilitation services." The subject study looked at claims data and these data alone could not define the "effective use" of physical rehabilitation services is. Claims data reflects the cost of a single medical intervention. It does not provide insights into the total cost of an entire episode of care. Other data sources, beyond just claim data, were not considered definitive for this purpose.

  Therapy visits can be less expensive on a per visit basis but we cannot assess the value of such care because claims data alone does not assess the clinical appropriateness or effectiveness of the care rendered.

  One presumes that the intent of this question is to determine the point at which physical rehabilitative services can avoid more expensive treatment or therapies that might have been performed if the rehabilitation had not been employed. In this context, it would appear that access to physical therapy, occupational therapy, and speech therapy would be effective at curtailing more expensive care options. However, a thorough cost benefit analysis was not performed to verify this presumption. Although the cost per visit for such therapies is less expensive than the cost for more specialized and possibly intrusive medical care, the number of therapy visits per episode would have to be assessed to be able to draw this conclusion. Again, these data were not available through claims data alone.

- ***What impact will reductions in cost-sharing have on premiums?***
  "Reductions to member cost-sharing for rehabilitation services in insured products will increase the premiums somewhat, depending on the level of cost sharing reduction. Such premium increases will likely be modest in size." This statement is clear. However, the study does not conclude that access to more rehabilitative services will necessarily be efficacious versus other potential types of care which might be more expensive or more extensive.

  The Commission on Affordable Health Care is seeking approaches to reduce the cost of care. Using therapists to render readily available, local, and affordable health care is certainly desirable. The key variable however is the total cost of the entire episode of care (number of visits x the cost per visit) and it could not be determined from the data that in that context rehabilitative care proves that it is necessarily more effective than more intensive alternatives. That said, even without conclusive data on episodes of care, it might be assumed that this proposition can be supported in most instances.

- ***What other observations can be made?***
  It is important for the reader to note that the impact of copayments (flat dollar amounts that are paid when care is rendered) is diminishing in the Colorado market as more plans move to deductibles (a flat amount per plan year) and coinsurance (percentage of the allowed charge that is the responsibility of the member). The rapid growth of high deductible Health Savings Accounts (HSAs) are one manifestation of this change. HSA plans do not allow office visit copayments.

With more experience, over time, we can determine how utilization is impacted when deductibles and out-of-pocket limits are met, as the plan year progresses. This is a topic that is certainly worthy of additional consideration, but it was beyond the scope of the study.

Another consideration worthy of noting is that insurers also often use internal visit limits, along with cost sharing amounts, to limit unnecessary care. These limits restrict the number of visits that can be obtained by the patient, regardless of medical necessity. In many policies, these limits are even combined (i.e., 20 visits for the combination of physical therapy, occupational therapy, and speech therapy) which further restricts access to such care.

Thus, policy makers need to look beyond just the amount of cost sharing when they seek to assess the limitation of access to therapy services.

The Commission on Affordable Health Care is determined to use quantifiable, statistical data and academic research to base its opinions upon. We regret that the state of such background does not permit a more direct, or clear opinion at this time.

We trust that this amplification of the Milliman report will be helpful to the readers of the report .

This additional detail is respectfully submitted by the Commission on Affordable Health Care.