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OFFICIAL STATEMENT

The Honorable Donald White
Chair, Banking and Insurance Committee
Senate Box 203041
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Room: 286 Capitol Building

Testimony of Justin Moore, PT, DPT, on SB 594 – Fairness in Copayment Act
Pennsylvania Senate Banking & Insurance Committee

May 6, 2014

Chairman White and Members of the Banking and Insurance Committee:

On behalf of the American Physical Therapy Association (APTA), it is my honor to submit testimony in support of ***SB 594 – Fairness in Copayment Act*** before the Pennsylvania State Senate Banking and Insurance Committee. I am Justin Moore, Vice President of Public Policy, Practice, and Professional Affairs at APTA. APTA is the national professional association representing more than 88,000 physical therapists, physical therapist assistants, and students of physical therapy nationwide and more than 4,100 in the Commonwealth of Pennsylvania. APTA strongly supports SB 594, legislation that will ensure fair copays and access to care for the patients and clients we serve.

Physical therapy is a highly effective alternative to prescription medication and surgery for many conditions.[1] Research shows that individuals who receive regular physical therapy treatment experience greater improvement in function and decreased pain intensity.[1] Studies also indicate that early and appropriate access to physical therapy results in significant cost savings for employers, insurers, and patients.[2,3]

Unfortunately, the value and cost-effectiveness that physical therapists bring to the health care system are diminished by excessively high copayments, which have the potential to decrease patient access and outcomes, while driving up costs. Due to physical therapy's categorization as a "specialty" health service, patients' copayment responsibilities can reach as high as $75 per visit, which can at times exceed the total cost of services. Since physical therapy frequently requires multiple visits over an extended period of time, many patients seeking physical therapy may pay excessive amounts, possibly over $600 per month, in out-of-pocket expenses, in addition to their monthly premium, to access essential treatment.

The excessive copay amounts often result in patients paying more out of pocket for physical therapy than they do for any surgery, imaging, or pharmacy benefits that they have had. In some cases, the amount paid in patient copays covers the entire cost of the services provided, thus negating the entire purpose of a physical therapy "benefit" offered by insurance companies.

Excessive copay amounts are a disincentive for patients to seek physical therapy, resulting in a lack of compliance for their care. This only leads to higher costs for health care in the future, with the potential for significant recurrence and downstream costs including further surgery, imaging, and prescription drugs.

As a result of the mounting concerns and frustrations expressed by the patients we serve, in 2011 APTA adopted a position outlining our support for state legislation that would require payers to place reasonable limits on the patient's financial responsibility for physical therapist services. Since 2011, fair physical therapy copay legislation has been enacted in Kentucky, South Dakota, Arkansas, Connecticut, and Missouri. In addition, legislation was or is currently being considered this year in Iowa, Colorado, Massachusetts, New York, New Hampshire, Nebraska, Tennessee, and Washington. APTA is not aware of any increased premium costs to employers or patients as a result of such enacted legislation, and data analysis has shown that minimal impact on premium cost is expected.[4]

The issue of decreased access and poor outcomes as result of excessively high copay is not limited to just physical therapy. A 2010 study published in the *New England Journal of Medicine* showed that increased copayments for ambulatory care and hospitalizations among the elderly may have adverse health consequences and may increase total spending on health care.[5] A 2009 report published in *The American Journal of Managed Care* shows that while, ideally, higher patient copays would discourage only the utilization of low-value care, evidence from the Rand Health Insurance Experiment (HIE) demonstrates that increased cost-sharing also reduces use of high-value services.[6] Numerous recent studies that examine cancer screening and high-value prescription drugs confirm that excessive cost-sharing affects the use of even potentially life-saving services. Specific to physical therapy, at least 2 payers in the Commonwealth have established "bundled" copayment programs to increase member access and promote conservative treatment when appropriate. In apparent recognition of access issues associated with current copayment amounts, these programs allow a patient to pay 1 copayment for multiple physical therapy visits.[7]

Meaningful coverage and appropriate patient cost-sharing are key tenets of the Affordable Care Act. The ACA mandates the coverage of essential health benefits, including rehabilitative services such as physical therapy. While the law provides overall cost-sharing protections and guidance, it neglects to protect consumers from unreasonable cost-sharing that impedes access to vital care. Due to the lack of service-specific protection, such as fair copay regulation for enrollees, states such as

Pennsylvania should have the flexibility to create protections that ensure access to essential benefits such as physical therapy so long as those protections do not directly conflict with any ACA provisions.

This is mentioned directly in the ACA under Section 1321(d), stating that "nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title"—meaning that states can go beyond the federal law, but if a state's laws or regulations prevent a federal law from being implemented, then that law or regulation is preempted.

A provision on copays that is more protective of consumers in this regard does not prevent the application of the provisions of Title 1 of the ACA; hence, it does not conflict with federal law and would not only be allowable under the ACA, but is the type of protection that ensures access to care in the spirit of the ACA.

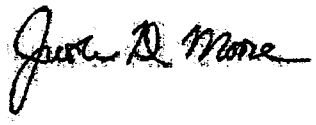
In addition, SB 594 would not significantly affect the cost to Pennsylvania and its employers and insurers. Data analysis has shown that implementation of a fair copay law does not largely impact the total per-member per-month cost, which indicates minimal impact on premium cost.[4] As a result, patients will receive necessary services at lower cost with little to no impact on premium cost. Further, a copay limitation for physical therapy will have minimal impact on plans sold on Pennsylvania's health insurance exchange that must adhere to specified actuarial value percentages. Data produced by the California Health Benefits Review Program demonstrates that physical therapy represents a minimal portion of the actuarial costs (about 1.3%) for a large group health plan.[8] Therefore, a reduction in copays for physical therapist services would require minimal, if any, adjustments to other cost-sharing policies in the insurance plan to remain within the designated metal-level actuarial values.

Additionally, SB 594 would not add to state costs under the ACA. Specifically, language In the Essential Health Benefits regulations of the ACA[9] explicitly states that this type of law would ***not*** be subject to the state-required benefits provision, which would require the state to pay for the cost of the additional requirement. In fact, the Centers for Medicare and Medicaid Services (CMS) has explicitly stated that the state mandate provision applies only to **"the care, treatment and services** that an issuer must provide to its enrollees." Other state laws that do not relate to the coverage of care, treatment, and services, including those relating to cost-sharing, provider reimbursement, and benefit delivery method, are not subject to this requirement.

In closing I want to stress that APTA is not opposed to appropriate insurance cost-sharing models; however, we are opposed to inappropriately ***cost shifting*** the majority of the financial burden onto the patient for services that are supposed—and in some cases required—to be covered. If enacted, SB 594 will help to alleviate this situation for the patients we serve.

Again, APTA strongly urges the passage of SB 594. Thank you for the opportunity to provide our perspective on this important legislation, and thank you for your service to the people of Pennsylvania.

Respectfully submitted,



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[7] Geisinger Health Plan Operations Bulletin Re: Medical Spine Management Program (June 20, 2013).

[8] Appendix 13: The California Cost and Coverage Model An Analytic Tool for Examining the Financial Impacts of Benefit Mandates, California Health Benefits Review Program. http://www.chbrp.org/other_publications/docs/ap_13.pdf.

[9] 45 CFR § 155.170.