APTA
American Physical Therapy Association

OFFICIAL STATEMENT

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The Honorable Donald White
Chair, Banking and Insurance Committee
Senate Box 203041
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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.

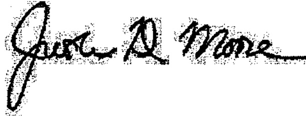
In addition, SB 594 would not significantly affect the cost to Pennsylvania and its employers and insurers. Data analysis has shown that implementation of a fair copay law does not largely impact the total per-member per-month cost, which indicates minimal impact on premium cost.[4] As a result, patients 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,



Justin Moore, PT, DPT
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[4] Lewis & Ellis Inc. Report for the Joint Committee on Legislative Research-Oversight Division: Actuarial Service Review of SB 262, SB 159, and SB 161. December 20, 2013. http://www.moga.mo.gov/oversight/over13/PDFs/Missouri%20Legislative%20Committee%20Report_SB262_SB159_SB161.pdf.
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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.

May 6, 2014

Testimony of Jeff Ostrowski, PT

Senate Bill 594, Printer's No. 1943

I respectfully ask that you allow this letter to serve as my written testimony regarding Senate Bill 594, Printer's No. 1943 (SB 594) and include this letter as part of the official hearing record. SB 594 is of concern to me in my role as a licensed physical therapist practicing in the Commonwealth of Pennsylvania. For the reasons set forth below I strongly support SB 594 and its underlying premise of the need in the Commonwealth of Pennsylvania for a mechanism to establish, and subsequently enforce, reasonable cost sharing amounts for physical therapy.

The heath care system is best and most economically served when patients have access to low cost, low risk, high quality interventions. Physical therapy is one such intervention. Physical therapists are low cost providers in the health care continuum. Money spent on physical therapy can save downstream costs by preventing the need for surgeries, hospitalizations and chronic use of medications. All of these options are more expensive and have significant risk factors that are not seen with physical therapy treatment. Physical therapy care has been shown to prevent the need for patients to access these riskier and more expensive options. High co-pays encourage patients to opt out of therapy. The alternative is more expensive procedures which cause costs to go up for all of us. Other testimony that you will hear or read today provides references to studies that support these statements; I personally see this play out every day with physical therapy patients in the Commonwealth.

I have the opportunity to work with approximately 80 physical therapists who provide services in many clinics in Philadelphia and the surrounding counties. I can tell you that not a day goes by when the topic of high copayments is not discussed in some capacity. One specific area of discussion is often patients who self-discharge from therapy due to high co-payments before a plan of care is completed or patients who otherwise attend therapy at less than frequency recommended by the referring physician. An example is a patient who has had a knee replacement. Often times, these patients develop stiffness and weakness which impedes walking and other necessary functions. Physical therapy is an essential component of the post-operative care. Without it, the surgical procedure is not optimized. A high co-payment may cause a patient to self-discharge before they have returned to optimal function. This patient may not be able to return to work as soon as possible. The patient may need to give up on activities they want and need to do or not be able to perform essential functions. In the worst case scenario, the patient may require more invasive medical procedures to address the chronic issues that could have been adequately addressed by completing the therapy plan of care.

In addition to regular discussions with fellow therapists, our staff is in regular contact with physicians who recognize the value of physical therapy and seek to refer their patients. Many of these physicians express similar frustration over high copayments for physical therapy. For example, physicians tell us that many patients who they refer to therapy (some estimate 50%) never actually attend even one session of therapy. When a reason is asked, many of the patients site high co-payment as the reason for forgoing recommended physical therapy care. From a "cost to the healthcare system" perspective, many physicians have also reported to our staff that they are required to spend increasing amounts of time convincing patients that physical therapy is necessary to treat their respective injury. Physicians have reported to our staff that they simply can not take on the administrative burden of taking ten minutes to

convince a patient that physical therapy, despite the often high copayment associated with it, is necessary to achieve an optimal outcome.

For the reasons illustrated above, I strongly support SB 594. Thank you for allowing me the opportunity to provide testimony regarding this legislation.

Very truly yours,

Jeff Ostrowski, PT

Senate Banking and Insurance Committee

Senator Donald C. White, Chair

Senate Bill 594, Printer's No. 1943

May 6, 2014

Testimony of Jennifer Woods

I respectfully ask that you allow this letter to serve as my written testimony regarding Senate Bill 594, Printer's No. 1943 (SB 594) and include this letter as part of the official hearing record. For the reasons set forth below I strongly support SB 594.

My name is Jennifer Woods and I have traveled here today from Lock Haven, Pennsylvania to testify in favor of Senate Bill 594. I have been under the care of a licensed Occupational Therapist after surgery on my left forearm and wrist. On February 22, 2014, I was involved in a life changing accident at my home. Since the accident, I have lost the use of my left hand and have been unable to work due to my extensive injury. After a period of recovery time to allow healing of certain surgical procedures, I was prescribed Occupational Therapy by my surgeons, (3, because of the severity of the surgery). Occupational Therapy was prescribed two (2) times a week. Due to the high cost and frequency of my co-pays, I am unable to attend my rehabilitation two (2) times a week; I have to limit this treatment to once a week. My recovery from this point on in my injury is dependent upon my rehabilitation in Occupational Therapy and the benefit the therapy gives me. At this point, Occupational Therapy at this point, is the most important part of my recovery. I cannot work now and have no income for myself. My job is driving a truck. We are stretching my husband's income as far as we can to pay the bills, but there is no room for any more co-pays. I also have to pay co-pays to my 3 surgeons for follow-up appointments and continue to pay my employer for my health care coverage. Something needs to be done for people like me in this position with this type of injury and the high cost and amounts of co-pays being charged by the insurance company. The high cost of these co-pays creates a barrier for me to access these services that I need very badly to regain full use of my hand. My recovery, because of the high cost of these co-pays and my difficulty in paying them, has been very slow with no ability to begin working again at this time.

For the reasons stated above, I strongly support SB 594. Thank you for allowing me the opportunity to provide testimony regarding this legislation.

Sincerely,

Jennifer Woods