SENATE BILL 594 TESTIMONY
Pennsylvania Chiropractic Association
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The Fairness in Co-payments Act, SB 594, was introduced by Senator Chuck McIlhinney (R-Bucks) in the interest of health consumer protection and overall fairness when it comes to co-payments for physical medicine services rendered. SB594 has been approved by this Committee on two prior occasions.

On the behalf of over 4,000 Doctors of Chiropractic (DC) represented by the Pennsylvania Chiropractic Association and millions of their patients, I welcome the opportunity to present testimony in favor of passing this important legislation in the Senate, through the House and on to the Governor's desk, as soon as possible.

Senate Bill 594 is a common sense, consumer protection measure that will assure patients do not face excessive co-payments because of a health insurance company policy.

After many months of discussions and negotiations with the health insurance industry and many language changes to the original legislation, this Committee adopted an amendment that we believe is reasonable and fair to patients, providers, and insurers. It is a compromise that accommodates all of the concerns you have heard from the insurance industry and is consistent with similar legislation in other states.

By calling for "reasonable participation by both insurers and the insured," the bill will assure that we do not inappropriately shift the cost of healthcare to the consumer with excessive copays. In some circumstances, patient's copayments actually exceed the cost of their care. In many cases, the amount paid by insurers is so low that patients are bearing an excessive, out-of-pocket burden – even though they may have purchased insurance policies that supposedly cover these services. (see page 4 for specific examples of unfair copays).

This cost shift imposes an inappropriate financial burden on patients, and it has resulted in restricted access to certain services, particularly Chiroprctic, Physical Therapy, and Occupational Therapy performed in an out-patient setting.

I speak for all of my patients and for the Pennsylvania Chiropractic Association, in asking for your strong support of SB 594.

There are several important points I would like to share with you today.

First, it is a total red herring to suggest that the Affordable Care Act somehow precludes equitable co-pay arrangements. The federal government has given plenty of flexibility to states in implementing the ACA and I am confident that we can figure out how to reach whatever actuarial equivalences are required.

Second, the bill singles out Chiropractors, Occupational Therapists and Physical Therapists, because that is exactly what the insurers asked us to do. Rather than apply the "reasonable" standard system-wide, we focused on those health care professions where patients are having the biggest problems with excessive co-payments.

Third, the notion of "reasonable" does NOT strike us as being overcomplicated or difficult. It is deliberately vague so that all parties can come to terms on what truly is "fair." For example, **it is NOT reasonable or fair to say that a service is covered by an insurance policy if the patient makes a copay and the insurer makes "NO-pay."** We made several legislative suggestions for a specific percentage or dollar amount but, again, revised the bill at the insurers' request to address "reasonableness" administratively; not by statute.

Fourth, it is disturbing that the insurers have suggested that paying their fair share of a co-pay could result in higher deductibles. **Surely, with the vast financial reserves that the health insurance companies have built up, insurers could accommodate reasonable co-payments without further reaching into consumers' other pockets.**

Finally, and most disturbing, we have heard insurance companies suggest that excessive co-pays are a way to discourage "overuse" of certain healthcare procedures. But it doesn't just discourage "overuse", it discourages appropriate, medically necessary "use". Insurers already have "pre-service" utilization management and "post-service" utilization review policies in place to make sure that services rendered are medically necessary and appropriate, they don't need to use high out of pocket expenses for patients to discourage utilization. **While their current policies clearly save insurers money, they impair the ability of patients to afford physical medicine services when they are most needed.** This is especially troublesome for patients of DC's, PT's, and OT's, where successful outcomes depend upon multiple visits in a treatment plan.

When the co-pays are excessive, patients tend to prematurely discharge themselves from care, they delay treatment, they self treat, they self medicate, and ultimately can end up spending more health care dollars in interventional pain management or surgical care. **Fair and reasonable co-pays do not increase health care costs; they decrease health care costs.**

You may be wondering if any other states have faced this same issue. The answer is yes- plenty of them.

Here is a quick summary of Fairness in Co-Payments laws from other states:

Delaware
"Any copayment or coinsurance amount shall be equal to or less than **twenty-five percent (25%)** of the fee due or to be paid to the doctor of chiropractic under the policy, contract, or certificate for the treatment, therapy, or service provided."
http://delcode.delaware.gov/sessionlaws/ga146/chp165.shtml

Kentucky
"An insurer shall not impose a copayment or coinsurance amount charged to the insured for services rendered by a chiropractor licensed under KRS Chapter 312 or an optometrist licensed under KRS

Chapter 320 that **is greater than the copayment or coinsurance amount charged to the insured for the services of a physician or an osteopath licensed under KRS Chapter 311 for the same or similar diagnosed condition**, even if different nomenclature is used to describe the condition or complaint." http://www.lrc.ky.gov/Statutes/statute.aspx?id=17392

Louisiana

"A health insurance issuer must apply the **same co-payment, coinsurance, deductible, and benefit limitation to a licensed chiropractor as it does to any other health care provider** with regard to a health care service for the same or similar medical condition." http://www.ldi.louisiana.gov/docs/CommissionersOffice/Legal/Directives/Dir203_Cur_PaymentAndReimburseme.pdf

Missouri

"This legislation prohibits health carriers and health benefit plans from imposing any co-payment that exceeds **fifty percent** of the total cost of providing any single chiropractic service to its enrollees." http://insurance.mo.gov/Contribute%20Documents/Bulletin09-01.pdf

South Dakota

"Copayment or coinsurance amounts for chiropractic, physical therapy, or occupational therapy services. No health insurer may impose any copayment or coinsurance amount on an insured for services rendered by a doctor of chiropractic licensed pursuant to chapter 36-5, an occupational therapist licensed pursuant to chapter 36-31, or a physical therapist licensed pursuant to chapter 36-10 **that is greater than the copayment or coinsurance amount imposed on the insured for the services of a primary care physician or practitioner for the same or a similar diagnosed condition** even if a different nomenclature is used to describe a condition." http://legis.sd.gov/statutes/DisplayStatute.aspx?Statute=58-17-54.1&Type=Statute

When you cut through all of the jargon and the objections raised by the health insurance industry, the issue remains very simple: If two parties enter into a co-pay arrangement, shouldn't both parties pay something that is fair and reasonable? Isn't that what the "co" in "co-payment" means?

I ask you to pass SB 594 as soon as possible so we can assure all of our patients that they are being treated fairly in Pennsylvania.

Thank you for your consideration of PCA's testimony regarding Senate Bill 594, the FAIRNESS in Co-payment Act.

RECENT EXAMPLES OF UNFAIR CO-PAYMENT POLICIES

Capital BlueCross (policy #80138466700)
Spinal manipulation is performed (cpt 98940) with a charge of $26.00. Electric stimulation is performed (cpt 97014) with a charge of $10.00. The copay is $40.00; the total charge is $36.00. The patient pays $36.00 and the insurance pays nothing.

On follow up visits spinal manipulation is performed (cpt 98940) with a charge of $26.00. The copay is $40.00. The patient pays $26.00 and the insurance pays nothing.

As an extreme example of how Capital BlueCross shifts costs entirely to patients, if on one visit to a network participating Doctor of Chiropractic a patient were to receive spinal manipulation (cpt 98940), electric stimulation (cpt 97014), one hour of therapeutic exercise (cpt 97110), mechanical traction (cpt 97012) and two units of ultrasound (cpt 97035), the maximum visit charge would still be limited to $36.00 with a $40.00 copay.

United Healthcare (policy #978153752)
Spinal manipulation is performed (cpt 98940) with a charge of $25.00. Mechanical traction is performed (cpt 97012) with a charge of $11.00. The charge for the visit is $36.00, the patient pays a $35.00 copay and the insurance pays $1.00.

Highmark PPO Blue (policy #111306100001)
Patient presents with a new problem. Established patient examination is performed (cpt 99212), on the same visit spinal manipulation (cpt 98941) is performed, and on the same visit electric stimulation (cpt 97014) is performed. The patient is charged 3 copayments on the same date of service, one for each service provided.

Highmark Flex Blue PPO (policy #109922715001)
New patient presents for examination (cpt 99202). The charge is $60.00. The copay is $50.00. The patient pays $50.00 and the insurance pays $10.00.

The patient returns with a new complaint for examination (cpt 99212). The charge is $40.00. The copay is $50.00. The patient pays $40.00 and the insurance pays nothing.

Health America Advantra (policy #850450162-01)
New patient presents for examination (cpt 99292). The charge is $60.00. This is a non covered service, the patient pays $60.00.

Follow up visits include:

Electric stimulation (cpt 97014) charge of $20.00. This is a non covered service, the patient pays $20.00. Spinal manipulation (cpt 98941) charge of $23.16. Patient has a $20.00 copay for this service. Total charge for follow up visit is $43.16. Patient pays $40.00 and insurance pays $3.16.