New York State Occupational Therapy Association

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Memorandum of Support

Insurance Reform for Rehabilitation Services

A.3757 by Assembly member Gunther
S.964 by Senator Breslin

This legislation amends sections 3216, 4235, 4301 & 4322, 4406-d, 4803, 4901, 4902, 4905 of the insurance law, and provides that no policy of group accident, group health or group accident and health shall impose co-payments in excess of twenty percent of the total reimbursement to the provider of care. The legislation adds coverage of occupational therapy services to not-for-profit health plans. This legislation creates an exceptions process for out-patient visit limits. The legislation also provides greater disclosure of utilization practices and the prohibition of certain practices.

The New York State Occupational Therapy Association supports this legislation.
This bill will protect consumers by prohibiting plans from inappropriately shifting the cost of therapy care to consumers by limiting co-payments to no more than 20 percent of the total reimbursement to the provider of care. Under existing law, health plans must cover physical and occupational therapy services. Despite that requirement, health plans have shifted the vast majority of the cost of physical and occupational therapy services by imposing increasingly higher co-payments onto consumers. Under certain health plans, co-payments for therapy services have exceeded the reimbursement paid by the plan to the provider of care.

This cost shift has imposed a financial burden on consumers, affected access to physical and occupational therapy services and defeated the purpose of insurance coverage.

Patients frequently cannot afford the cost imposed by these copayments, especially at a time when they are ill and out of work. Co-payments for health care services that require infrequent visits can be a reasonable health care financing policy. However, in the case of medically necessary physical therapy and occupational therapy care multiple visits over an extended recovery process is often required. Excessive co-payments for each therapy visit leads many patients into choosing between family expenses and recovery. For example, a co-payment of $50 for an occupational therapy plan of care at 3 times a week over one month will cost the consumer $600 in out-of-pocket expenses which is beyond the means of many consumers. As a result, New Yorkers are forgoing medically necessary care running the risk of partial recovery, worsening the underlying condition or risking re-injury.

This legislation will still allow health plans to require co-payments that discourage inappropriate care but will prohibit plans from inappropriately shifting the cost of physical and occupational therapy care to consumers.

Health care economist Gerald Friedman states, “For 40 years, many economists' have promoted increasing cost sharing through higher copayments and deductibles, the replacement of fee-for-service payment systems with capitation where providers are paid a fixed amount for patients as in Health Maintenance Organizations, and competition where multiple insurers offer a variety of plans catered to individual consumer's interests and in competition with each other. Far from limiting health care cost increases, these practices have produced the worst of all worlds, rising costs along with restrictions on access. Costs have risen because these recommendations have inflated the administrative burden in health care, the costs of the billing and insurance activities within provider offices as well as the cost of the health insurance industry itself. While restricting access, limiting the benefit to Americans of some of the dramatic improvements in health care practice of the last decades, these practices have not bent the cost curve or slowed health care inflation even while denying more and more Americans access to affordable health care.”

This legislation adds occupational therapy as a covered service under not-for-profit insurance plans. Occupational therapy is a covered service in all other types of health insurance plans but was inadvertently omitted from section 4322 of the insurance law.

This legislation creates an exceptions process for out-patient visit limits. Currently many commercial health plans limit out-patient therapy visits to a specific pre-set number, such as twenty visits per profession. In many cases this limit is sufficient for recovery. However, there are some injuries or illnesses that leave the patient with extensive disability and a lengthier course of recovery. An arbitrary visit limit does not meet the coverage needs of that patient. This proposed legislation would provide for an appeals process that would include a physician’s certification that such a cessation of therapy would most likely result in harm to the patient. The legislation further authorizes the superintendent of the Department of Financial Services to further determine the appeals process through regulation.

Managed care practices have become increasingly aggressive and protections enacted in 1996 have eroded as plans have found ways to implement procedures consistent with the law but detrimental to health care. This legislation would reestablish fair and appropriate utilization practices consistent with the underlying purpose of the 1996 Managed
Care Reform Act.

This legislation reforms utilization review procedures by prohibiting health care plans from compensating utilization review agents on a percentage basis or other method which would provide a financial incentive to deny claims. A practice that puts undue influence on coverage determinations.

This legislation would prohibit a health plan from terminating or refusing to renew a contract on the basis that a provider ordered or rendered medically necessary care. A practice of intimidation that interferes with the professional practice of health care.

Further, this legislation would require utilization review agents to disclose any adverse determinations regarding the provision of therapy services to both the patient and the provider.

This legislation would require health plans and utilization review agents to report to the Department of Health and the Department of Financial Services respectively the clinical review criteria and standards, the definition of medical necessity used under the utilization plan, as well as any amendments to their utilization review plan.

Finally, this legislation would allow a health care provider to request clinical review criteria and other clinical information which the health care plan might consider in its utilization review. This allows the provider to understand what treatment options are available to the patient and how to plan an approach to treatment that maximizes the patient's recovery.

For all of the aforementioned reasons NYSOTA asks the legislature to pass this legislation.