October 4, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–1656–P
PO Box 8013
Baltimore, MD 21244–1850

Submitted Electronically

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018

Dear Acting Administrator Slavitt:

On behalf of our 93,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) regarding the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 (“Benefit and Payment Parameters”). Physical therapy is an integral service to the total spectrum of patient care, and, therefore, we are very interested in this proposed rule and its impact on access to therapy services.

The physical therapy profession is committed to the restoration, maintenance, and promotion of optimal physical function. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status across all age populations. Physical therapists also help patients maintain health by preventing further deterioration or future illness. Maintaining access to physical therapy services is integral to ensure patients’ recovery and to prevent further deterioration of patients’ conditions. APTA looks forward to working with CMS to address potential barriers to physical therapy services imposed by marketplace health plans.

As CMS works to implement the policies proposed in this rule, we strongly urge the agency to consider the following recommendations:

1. APTA encourages the broad application of copay caps to therapy services, and commends CMS’ efforts to support state limits on copays for therapy services.
2. APTA recommends that CMS include physical therapy services, rehabilitation services, and habilitation services to satisfy the “major services” requirement for de minimis bronze plans.

New Standardized Plan Options for States

In the 2016 Benefit and Payment Parameters final rule, CMS finalized standardized plan options (or “Simple Choice Plans”) that states could implement for their health insurance plans. These plans were designed with identical deductibles, cost-sharing limits, copayments, coinsurance amounts, and key health services. Under these plans, CMS set a 20% coinsurance amount for physical therapy, speech-language pathology, and occupational therapy services. In certain states, this amount caused the price of therapy visits to exceed that of primary care visits, which is prohibited by certain state laws.

To correct this flaw, CMS has proposed new Simple Choice Plans for the 2018 plan year that can be used in states with restrictive cost-sharing laws. These new plans would impose a $30 copay for physical therapy, speech-language pathology, and occupational therapy services rather than a 20% coinsurance amount. The proposed copay would not be subject to the plans’ deductible.

APTA commends CMS’ plans to support states that limit copay amounts for therapy services to ensure that consumers can afford these necessary health care services. Consumers in these states will have increased access to therapy services, which translates to reduced health care costs and the continued improvement or maintenance of their health conditions.

While APTA applauds CMS’ support of states that prevent excessive therapy copays, APTA recommends that the agency extend the $30 copay to all Simple Choice Plans. Physical therapy typically requires multiple visits over an extended period of time to ensure patients’ complete recovery from injuries and improvement of their overall function. The number of visits needed often requires consumers to pay $600 per month in out-of-pocket expenses (or more depending on state coinsurance amounts) in addition to their monthly costs for health insurance. Excessive coinsurance and copay amounts can lead consumers to limit necessary physical therapy visits or forgo therapy altogether, creating poor outcomes and complications, and eventually leading to higher costs to health plans.

De Minimis Bronze Plans

Under the Benefit and Payment Parameters proposed rule, CMS proposes to give marketplace health plans more flexibility in their design of “de minimis” bronze plans.
Current ACA regulations allow de minimis bronze plans to have an actuarial value (AV) of 58% and higher. This means that some de minimis plans do not cover any services before the consumer pays the deductible, thereby offering less coverage than catastrophic plans, which cover 3 primary care visits before the deductible is paid.

Physical Therapy as a Qualifying Major Service

In the proposed rule, CMS notes that the Secretary did not intend for bronze plans to provide less coverage than catastrophic plans. To correct this imbalance, CMS proposes to give health plans more flexibility in bronze plan designs, allowing plans to have an AV variation between -2 and 5 percentage points from the 58% AV. Health plan issuers would qualify for this increased AV range only if they cover and pay for a major service, similar to the 3 primary care visits covered under catastrophic plans.

In its proposal, CMS lists the following qualifying major services:

- Primary care visits
- Specialist visits
- Inpatient hospital services
- Generic services
- Specialty or preferred branded drugs
- Emergency room services

APTA appreciates CMS’ efforts to allow more flexibility in de minimis bronze plan design to account for the various health care needs of enrollees. However, APTA is concerned that patients who require therapy services will be discouraged from obtaining the necessary therapy due to high deductible requirements. For this reason, we strongly urge CMS to add physical therapy services, as well as speech-language pathology services and occupational therapy services, to its list of qualifying major services, to ensure consumers have access to these integral health care services, even when they select de minimis bronze health plans.

Habilitation and Rehabilitation as Qualifying Major Services

In addition to including physical therapy and other therapy services as qualifying major services, APTA recommends that CMS include habilitation services and rehabilitation services to the list of qualifying major services for de minimis plans. Should de minimis bronze plans include rehabilitation services and habilitation services, it will be important to consider them as separate services, as they benefit discrete patient populations. Specifically, rehabilitation services help a patient keep, restore, or improve skills and functioning for daily living that has been lost or impaired due to illness, injury, or disability. These types of services include diagnosis and therapy interventions. Habilitation services help a patient keep, learn, or improve skills and functioning for
daily living. These services include therapy interventions that allow patients to manage their limitations and disabilities and prevent further deterioration in their conditions.

Giving consumers increased access to these integral services will ensure that they get the therapy services they need rather than forgo therapy, which over time would drive up costs to insurers and consumers.

**Conclusion**

APTA thanks CMS for the opportunity to comment on the ACA Benefit and Payment Parameters Proposed Rule for CY 2017. We look forward to working with the agency to provide efficient and high-quality care to Marketplace enrollees. If you have any questions regarding our comments, please contact Sharita Jennings, JD, senior regulatory affairs specialist, at 703/706-3391 or sharitajennings@apta.org.

Sincerely,

Sharon L. Dunn, PT, PhD
President

SLD: sj