Improving Access to Physical Therapy and Meeting the Needs of the Newly Insured

Combined Sections Meeting 2015

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Robert Sandstrom, PhD PT

Session Type: Educational Sessions  
Session Level: Basic

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HPA The Catalyst is the Section on Health Policy & Administration of the American Physical Therapy Association
Improving Access to Physical Therapy:
Meeting the Needs of the Newly Insured

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President, HPA the Catalyst, APTA
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Disclosure

• Dr. Gorman does not have a conflict of interest that might bias the content of the presentation.

• Dr. Sandstrom receives royalty payments from Pearson Education for Health Services: Policy and Systems for Therapists.

Objectives

At the conclusion of this session, the attendee will be able to:
– Describe the principles of access, health disparities and social justice that are addressed in the Patient Protection and Affordable Care Act of 2010.
– Compare and contrast the characteristics of the current therapy population with the characteristics of the population of the newly insured Americans needing health services.
– Define and discuss strategies to address disparities and improve access to physical therapy services for persons newly insured via the Patient Protection and Affordable Care Act of 2010.
Access to Health Care

• Ability to obtain health services when needed
• Access to care may be the leading cause of current crisis and affect health status
• Two forms: Financial, ability to pay
• Non Financial:
  – accessible with transportation, cultural, timely, language

Factors Affecting Access (Barton, 1999)

• Predisposing Factors- demographics
  – Age, Sex, race, education, SES, occupation
• Need Factors- decision making process
  – Perception of health status
• Enabling Factors- that interact or affect access
  – Convenience, income, insurance, health care organizations

Penchansky and Thomas (1981)

• Availability
  – relationship between services provided and services needed
• Accessibility
  – location and supply relationship
• Accommodation
  – temporal factors that create barriers
• Acceptability
  – Attitudes and perceptions of providers and patients
• Affordability
  – Price of care
Determinants of access

Three interrelated areas:
• Coverage (Accessibility)
• Cost (Affordability)
• Capacity (Availability)

Legend: Dark to light
• Highest uninsurance rate (20–27%)
• High uninsurance rate (16–20%)
• Moderate uninsurance rate (14–16%)
• Low uninsurance rate (10–14%)
• Lowest uninsurance rate (4–10%)

Figure 2.1: The Number of Non-Elderly Uninsured (in Millions)
Why people lack insurance?

• It’s the economy stupid!!
• Transition to low wage, low skill, part time, service type, nonunion jobs.
  – Manufacturing jobs 24%-15%
  – Service jobs 19-29%
• Rising cost of insurance to employers,
  – 50% increase from 1988-1998
  – 114% increase from 2000-2010
  – Experience rating, administrative costs affect small employers
• Loss of job, change jobs, part-time 21%
• Shift of cost to employee/family-30% in 2010

Who are uninsured?
(US Census Bureau, 2010)

• 12% white vs. 21% African-American, 32% Hispanic/Latino
• 27% of families with income < $25,000
• 9% of families> $75,000
• 50% of poor not covered by Medicaid
• 74% of uninsured are employed (2005)
• 26% are unemployed & Medicaid ineligible
Health Insurance and Health Use

• Uninsured less likely to have a regular source of care (56% vs. 10%) and delay needed care (Kaiser Family Foundation, 2010)
• Insured in poor health see a physician 70% more often than uninsured (IOM, 2004)
• 2009, 32% of uninsured reported postponing services secondary to cost vs 8% insured
• 28% not afford medication (Lasser, AJPH, 2006)
• African-Americans receive poorer care than whites on 66% of quality measures (King & Wheeler, 2007)

• Among a medically indigent population in California, loss of government-sponsored insurance was associated with decreased use of physician services and worsening control of hypertension. (Lurie, NEJM 1986)
• The uninsured are also more likely to visit the emergency department and be admitted to the hospital for “ambulatory care sensitive conditions,” suggesting that preventable illnesses are a consequence of uninsurance. (Oster, Weissman, JAMA 1992)
• The chronically ill uninsured are also less likely to have a usual source of medical care, decreasing their likelihood of receiving preventive and primary care. (Wilper, 2008)
• Discontinuity of insurance is also harmful; those intermittently uninsured are more likely to die than the insured. (Baker, 2006)

• The IOM identified 3 mechanisms by which insurance improves health:
  – getting care when needed
  – having a regular source of care
  – continuity of coverage
Health Outcomes

- 1971-1987 mortality rates found that the insured rate was 9.5% vs uninsured rate of 18.4%. After adjustment of other factors, lack of insurance was the factor that increased the risk 25% (Franks, JAMA 1993)
- 18,000 deaths annually due to lack of insurance (IOM, 2004)
- PT: fewer visits, delayed care due to lack of insurance, not comprehensive.


Andrew P. Wilper, MD, MPH, Steffie Woolhandler, MD, MPH, Karen E. Lasser, MD, MPH, Danny McCormick, MD, MPH, David H. Bor, MD, and David U. Himmelstein, MD

Uninsurance was associated with younger age, minority race/ethnicity, unemployment, smoking, exercise (less than 100 METs per month), self-rated health, and lower levels of education and income (P<.001 for all comparisons).

Regular alcohol use and physician rated health were also associated with higher rates of uninsurance (P<.05 for both comparisons).


<table>
<thead>
<tr>
<th>Age</th>
<th>U.S. population (millions)</th>
<th>Percent uninsured within age group</th>
<th>Total deaths</th>
<th>Uninsured excess deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>25–34</td>
<td>37,440</td>
<td>21%</td>
<td>40,548</td>
<td>1,930</td>
</tr>
<tr>
<td>35–44</td>
<td>44,780</td>
<td>15%</td>
<td>89,202</td>
<td>3,431</td>
</tr>
<tr>
<td>45–54</td>
<td>38,840</td>
<td>12%</td>
<td>162,545</td>
<td>4,734</td>
</tr>
<tr>
<td>55–64</td>
<td>23,784</td>
<td>14%</td>
<td>243,049</td>
<td>8,219</td>
</tr>
<tr>
<td>Total</td>
<td>144,044</td>
<td>16%</td>
<td>535,344</td>
<td>18,314</td>
</tr>
</tbody>
</table>
Estimated number of deaths resulting from uninsurance among adults age 25–64, applying the IOM methodology to the Census Bureau’s most recent insurance totals: 2000–06. (Uninsured and Dying Because of It: Urban Institute, 2008)

<table>
<thead>
<tr>
<th>Year</th>
<th>Population age 25–64 (millions)</th>
<th>Percent uninsured</th>
<th>Total deaths</th>
<th>Uninsured excess deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>146.1</td>
<td>15.5%</td>
<td>536,000</td>
<td>17,000</td>
</tr>
<tr>
<td>2001</td>
<td>147.8</td>
<td>16.1%</td>
<td>549,000</td>
<td>18,000</td>
</tr>
<tr>
<td>2002</td>
<td>150.3</td>
<td>17.1%</td>
<td>563,000</td>
<td>19,000</td>
</tr>
<tr>
<td>2003</td>
<td>151.5</td>
<td>17.7%</td>
<td>572,000</td>
<td>20,000</td>
</tr>
<tr>
<td>2004</td>
<td>153.4</td>
<td>17.6%</td>
<td>571,000</td>
<td>20,000</td>
</tr>
<tr>
<td>2005</td>
<td>155.6</td>
<td>18.1%</td>
<td>589,000</td>
<td>21,000</td>
</tr>
<tr>
<td>2006</td>
<td>157.7</td>
<td>18.7%</td>
<td>602,000</td>
<td>22,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>137,000</td>
<td></td>
</tr>
</tbody>
</table>

Infant Mortality (2003 CDC.gov- per 100 live births)

<table>
<thead>
<tr>
<th>Race, Bone-Latin</th>
<th>Infant mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5.7</td>
</tr>
<tr>
<td>African American</td>
<td>13.5</td>
</tr>
<tr>
<td>Latino</td>
<td>5.6 (healthy immigrant effect)</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>4.8</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>8.7</td>
</tr>
</tbody>
</table>

Age adjusted death rates-2004 US Dept of Health and Human Services- CDC.gov

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>African American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant Neoplasms</td>
<td>184.4</td>
<td>227.2</td>
</tr>
<tr>
<td>Coronary heart Disease</td>
<td>149.2</td>
<td>179.8</td>
</tr>
<tr>
<td>Stroke</td>
<td>88.0</td>
<td>109.9</td>
</tr>
</tbody>
</table>
Medicaid

- Medicaid improved health status of low income people but has limits. ([Lurie, NEJM 1984](#))
- 1975-1995 proportion of low income people insured by Medicaid fell due to eligibility changes.
- 1991, 26% physicians did not accept Medicaid patients, 35% limited number
- Intermediate level between insured and uninsured for access and use ([Halpern, 2007](#))
- Fewer prenatal visits and initiated later

Categories of Underinsurance

- Lack of catastrophic coverage-caps
- Preexisting exclusions- HIPAA/Bill of rights
- Uncovered services- formularies
- Deductibles and Co-pays
- Medicare gaps
- Lack of coverage for long term care

The Affordable Care Act also provides important protections against health discrimination based on race, color, national origin, limited English language proficiency (LEP), sex, disability, and age, in Section 1557. Section 1557 applies to any health program or activity, any part of which receives federal financial assistance (including credits, subsidies, or contracts of insurance).
Underinsurance

- 17.6 million have insurance with major gaps in catastrophic coverage (Siefert, Health Aff, 2006)
- In 2001, 2 million Americans filed bankruptcy secondary to medical expenses (IOM)
- 14% have maximum lifetime caps of $250,000 or less, 65% have caps of 1 million.
- 60% of plans contained preexisting exclusions, waiting periods for coverage
- 2001-2006 deductibles and copays increased 60%, 5-6million in high deductible plans
- Childhood vaccinations dropped- measles increase from 2800(1985) to 26,500 (1990)

Uncovered services

- 1989, 55% of plans failed to cover childhood vaccinations, well baby care.
- Mammograms, Pap smears, PT services may not be covered or restricted.
- Deductibles and Co-pays, Medicare Gaps
- Long term care:
  - Medicare pays 4% of elderly nursing home

Insecurity

- “If you lose it, you lose it”
- Job lock
- Uninsurability if change job or insurance
- Less prevention use and services
Non financial barriers

• Location to services
• Lack of access to primary care
  – 53% of ED visits are non urgent (2003)
• Rural vs. inner city
• Infant mortality rates higher in rural vs urban
• PT services, 3x/wk location a factor

Gender

• Interactions between male or female patients and male or female physicians
• Male and female PT’s and different patient populations
• Patients of females physician 2x likely to receive a Pap smear, 1.4x likely to have a mammogram
• Following and MI, women less likely to be Rx ASA and Beta Blockers (AHQR, 2005)
• Women change physicians more often and have variety of problems including reproductive health concerns

Racial Bias

• Beyond financial alone; such as Medicaid and income restrictions/bias, fewer services provided with same coverage (IOM, 2003, King & Wheeler, 2007)
• Bias of providers (Van Ryn, 2002)
• Different medical problems
• Cultural differences and expectations (LaViest, 2000)
• Social inequality (Kawachi & Kennedy, 1999)
Health Status and other factors

• Income: Higher income in all races and genders show decrease in mortality rates
• Race:
  – African-Americans demonstrated 59,000 excess deaths from 1979-1981 than white people. Infant mortality is 2x for whites, rate of AIDS is triple than for whites
  – Asians have lower death rates than whites

Income , Race, Mortality rates
age adjusted death rates per 1000

<table>
<thead>
<tr>
<th>Income</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
</tr>
<tr>
<td>&lt;$9000</td>
<td>16.0</td>
<td>19.5</td>
</tr>
<tr>
<td>$9-14,999</td>
<td>10.2</td>
<td>10.8</td>
</tr>
<tr>
<td>$15-18,999</td>
<td>5.7</td>
<td>9.8</td>
</tr>
<tr>
<td>$19-24,999</td>
<td>4.6</td>
<td>4.7</td>
</tr>
<tr>
<td>&gt;$25,000</td>
<td>2.4</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Life Expectancy at birth- 2009

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950-White</td>
<td>69.02</td>
<td>72.03</td>
<td>66.31</td>
</tr>
<tr>
<td>1950-African American</td>
<td>60.73</td>
<td>62.70</td>
<td>58.91</td>
</tr>
<tr>
<td>2009- White</td>
<td>78.8</td>
<td>81.2</td>
<td>76.4</td>
</tr>
<tr>
<td>2009-African American</td>
<td>74.5</td>
<td>77.6</td>
<td>71.1</td>
</tr>
</tbody>
</table>
Infant mortality (per 1000 live births)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White-non-Latino</td>
<td>5.7</td>
</tr>
<tr>
<td>African American</td>
<td>13.5</td>
</tr>
<tr>
<td>Latino</td>
<td>5.6</td>
</tr>
<tr>
<td>Asian or Pacific Island</td>
<td>4.8</td>
</tr>
<tr>
<td>American Indian/Alaskan native</td>
<td>8.7</td>
</tr>
</tbody>
</table>

Age adjusted death rates (per 100,000 population)

<table>
<thead>
<tr>
<th>Disease</th>
<th>White</th>
<th>African American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>184.4</td>
<td>227.2</td>
</tr>
<tr>
<td>Coronary heart Disease</td>
<td>148.2</td>
<td>178.8</td>
</tr>
<tr>
<td>Stroke</td>
<td>88.0</td>
<td>98.9</td>
</tr>
</tbody>
</table>

Supply limits

- Controls of number of providers or specific material resources (ie; beds, MRI) (Fisher, 2000)
- Roemer’s Law
- Procedural limits (catherization, Caesarean)
- Geographic restrictions
- Types of provider limits (generalists vs specialists, NP and PA vs MD)
Summary

- Is access the cause of reduced health status among poor, low income individuals?
- Socioeconomic status vs poverty alone
- UK- looked at occupation
- Private insurance available to poorer minorities should minimize access affects.
- Illness not amenable to treatment vary with SES as well as amenable illness.

Does Medical Care Matter?

- Gap between rich and poor
- Role of medication, antibiotics, polio vaccine
- Hodgkin’s disease, breast and lung cancer
- Access to care does not guarantee good health, but without it health is certain to suffer!

Determinants of Health

- Birthplace
- Socioeconomic status
  - Education
  - Employment/Occupation
  - Income
  - Social support network
- Race and Ethnicity
- Access to health care
  - Insurance
  - Citizenship status
  - Adequacy of care or underinsurance (limited coverage and benefits)
- Environment
  - Neighborhood
  - Environmental Risk factors (i.e. clean air)
  - Potable water
  - Secondhand Smoke
Health Disparities - Colorado

• ~ 775,000 Coloradans (17% of the population) lack health insurance
  - 180,000 of those are children
  - 84% of uninsured are from working families;
  (The Piton Foundation)
• 15% of CO residents speak a language other than English in the home (Limited English Proficiency)
  (CO Department of Public Health and Environment)

Health Disparities – U.S.

• Racial Disparity
  - Lack Usual Source of Health Care
    • 30% Hispanic and 20% African-Americans vs. 15% of White Americans
  - Fair or Poor Health Among Non-Elderly Adults:
    • 17% Hispanic and 16% African-Americans vs. 10% of White Americans
• Gender Disparity
  - Of women who have a heart attack, 44% die within one year vs. 27% of Men
  (U.S. Department of Health and Human Services - Healthy People 2010)

Health Disparities – Globally

Top 10 Causes of Death

In the United States...
1. Heart Disease
2. Cancer
3. Cerebrovascular Disease
4. Chronic Lower Respiratory Diseases
5. Unintentional Injuries
6. Diabetes Mellitus
7. Pneumonia or Influenza
8. Alzheimer's Disease
9. Nephritis, nephrosis, or nephrotic syndrome
10. Septicemia

Throughout the World...
1. Heart Disease
2. Cardiovascular Disease
3. Acute Lower Respiratory Infections*
4. HIV/AIDS*
5. COPD
6. Diarrheal Diseases*
7. Perinatal conditions*
8. Tuberculosis*
9. Lung/Bronchial/Traches Cancer
10. Unintentional Injuries

* Not applicable in the United States
Social Justice and Health

• Health in America - [http://www.unnaturalcauses.org/video_clips_detail.php?res_id=213]
• Living in Disadvantaged Neighborhoods is Bad for Your Health - [http://www.unnaturalcauses.org/video_clips_detail.php?res_id=217]

Social Justice
Jost, J.T., & Kay, A.C. (2010)

• A state of affairs in which:
  – benefits and burdens in society are dispersed in accordance with some allocation principle
  – Procedures, norms and rules that govern political and other forms of decision making preserve the basic rights, liberties and entitlements of individuals and groups
  – Human beings are treated with dignity and respect not only by authorities but also by other relevant social actors, including fellow citizens.
  – Distributive, procedural, interactional justice

“The historic dream of public health...is a dream of social justice”

justice is fairness or reasonableness, especially in the way people are treated or decisions are made.²

The philosopher John Rawls (1971), in his book *A Theory of Justice*, argued that a society in which the most fortunate help the least fortunate is not only a moral society, but a logical one. He described the concept of a social contract, in which liberty is carefully balanced with individual rights and the overall good of society, with special emphasis on making the worst off as well off as they can be.

The United States is the *only* advanced economically developed country that has no comprehensive health care system for all citizens. Thirty-two of the thirty-three developed nations have universal health care, with the United States being the lone exception.

Improving Individual experience  
Better Health (Populations)  
Lower Growth in Expenditures  

Donald Berwick, MD  
The Triple Aim
Doesn't everyone have access to care?

- EMTALA (Emergency Medical Treatment and Active Labor Act) requires hospitals to provide emergency care regardless of ability to pay
- Emergency care does not equate to access to health care
- Lack of coverage impacts patient choices
- Human capital costs of lack of access to care is substantial

History of Affordable Care Act Insurance Reforms

- 2010
  - Children able to retain parental coverage until age 26
  - Ban on pre-existing conditions clauses for children
  - Lifetime caps on benefits lifted
- 2014
  - Medicaid expansion implemented
  - Health care exchanges open
  - Essential benefits established
  - Premium subsidies implemented
  - Ban on pre-existing conditions clauses for adults

Source: Commonwealth Fund Health Reform Resource Center

Increase Coverage

- Private insurance, self pay
- Medicare
- Medicaid: Pregnant women, children, disabled
- Non-pregnant adults under 65

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>400% FPL</td>
<td>Medicaid</td>
</tr>
<tr>
<td>138% FPL</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Non-pregnant adults under 65</td>
</tr>
<tr>
<td>Private</td>
<td>Medicare</td>
</tr>
</tbody>
</table>
Increase Coverage

Private insurance, self pay

- 400% Federal Poverty Level
- 138% Federal Poverty Level

Employer requirements and incentives

Uninsured

Medicaid

Pregnant women, children, disabled

Non-pregnant adults under 65

Medicaid expansion

Individual mandate, federal subsidy, purchase through Exchange

Medicaid

All individuals under age 65

Medicare

Non-pregnant adults under 65

Employer requirements and incentives

Uninsured
Health Reform
The Good

• 32 million new customers- 95% coverage
  –Combination of private insurance, Medicare and Medicaid
• Baby Boomers- growth sector
• Outcome oriented- accountability
• Evidence based
• Economic incentives

Exhibit 1. The Number of Uninsured Declined to 40.7 Million by January–March 2014

Source: Early Release of Selected Estimates Based on Data from the January–March 2014 National Health Interview Survey. U.S. Centers for Disease Control and Prevention, Sept. 2014.

Exhibit 9. More Than Three of Five Adults Who Selected a Private Plan or Enrolled in Medicaid Were Uninsured Prior to Gaining Coverage

What type of health insurance did you have prior to getting your new coverage?

After the End of Open Enrollment, the Percentage of U.S. Adults Who Are Uninsured Declined from 20 Percent to 15 Percent, or by 9.5 Million; Young Adults Experienced the Largest Decline Among All Adult Age Groups.

The ACA and Health Equity

- 39% of the newly insured under Medicaid expansion are racial/ethnic minorities
- Nearly half the adults uninsured adults eligible for subsidies through the marketplace are racial/ethnic minorities
- Funding will support public health programs to reduce disparities in reproductive health among racial/ethnic minorities

Across Incomes and Racial and Ethnic Groups, Adults with Low Incomes and Latinos Experienced the Largest Declines in Uninsured Rates.
The ACA and Health Equity

• Funds training for low-income individuals as health care paraprofessionals through historically minority colleges
• Includes strategies to recruit racial/ethnic minorities into health care provider and leadership roles
• Elevates the National Center on Minority Health and Health Disparities at NIH to Institute status, with planning and coordinating power to conduct health disparities research

Exhibit 3. The Percent of Uninsured Adults with Incomes Under 100 Percent of Poverty Fell Sharply in States That Expanded Medicaid; More Than a Third of Poor Adults Remained Uninsured in States That Did Not Expand Medicaid

<table>
<thead>
<tr>
<th>Total</th>
<th>Expanded Medicaid</th>
<th>Did not expand Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>July–Sept. 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>26</td>
<td>38</td>
</tr>
<tr>
<td>28</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>50</td>
<td>40</td>
<td>50</td>
</tr>
</tbody>
</table>

Note: States were coded as expanding their Medicaid program if they began enrolling individuals in April or earlier. These states include AR, AZ, CA, CO, CT, DE, HI, IA, IL, KY, MA, MD, MI, MN, ND, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV, and the District of Columbia. All other states were coded as not expanding.


Exhibit 7. Of Adults Who Visited the Marketplaces, Three of 10 Selected a Private Plan and One of Five Enrolled in Medicaid, by June 2014

<table>
<thead>
<tr>
<th>Did not select a private health plan or enroll in Medicaid</th>
<th>Selected a private health plan</th>
<th>Selected Medicaid</th>
<th>Selected a plan, but not sure if private or Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>46</td>
<td>29</td>
<td>19</td>
</tr>
<tr>
<td>Ages 19–34</td>
<td>47</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>Ages 35–49</td>
<td>49</td>
<td>29</td>
<td>17</td>
</tr>
<tr>
<td>Ages 50–64</td>
<td>42</td>
<td>36</td>
<td>16</td>
</tr>
</tbody>
</table>

Note: The question was asked only of those who said they had visited a marketplace. More people may have enrolled in coverage through Medicaid or a qualified health plan outside of the marketplace.

Exhibit 5. Seventeen States Had Higher Uninsured Rates Than the National Average in 2013. Of Those, 11 Have Yet to Expand Eligibility for Medicaid


Exhibit 6. Premiums and Cost Exposure Were the Most Important Factors in Plan Selection

What was the most important factor in your decision about which plan to select?

- Premiums: 58%
- Deductible and copayments: 34%
- Preferred provider included: 20%
- Other: 4%
- Did not formally select a plan: 1%
- Don’t know or refused: 4%


Exhibit 9. Adults with Low and Moderate Incomes Who Had Marketplace Coverage Had Deductibles Comparable to Those in Employer Plans

Note: FPL refers to federal poverty level. 250% of the poverty level is $28,725 for an individual or $58,875 for a family of four.

Exhibit 10: More Than Two-Thirds of Adults with Marketplace Coverage Rated Their Health Insurance as Excellent, Very Good, or Good

<table>
<thead>
<tr>
<th>Exellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Poor</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>All adults</td>
<td>16%</td>
<td>15%</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Employer</td>
<td>17%</td>
<td>17%</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>Adults with income below 250% FPL</td>
<td>18%</td>
<td>22%</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>Marketplace</td>
<td>15%</td>
<td>22%</td>
<td>15%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Note: FPL refers to federal poverty level.
250% of the poverty level is $28,725 for an individual or $58,875 for a family of four. Bars may not sum to 100 percent because of “don’t know” responses or refusal to respond; segments may not sum to subtotals because of rounding.

Continuing Issues

- Downward projections in enrollment growth
  - 9.9 million people to be enrolled in marketplace coverage by 2015; original CBO estimate was 13 million persons (Washington Post, 11/10/2014)
  - Only 2.6 million of an estimated 10.2 million uninsured, eligible Hispanics have gained health insurance. (Wall Street Journal, 11/11/14)
- Strains on segments of the health care system
  - Higher Medicaid enrollments= limited providers (Wall Street Journal, 11/13/14)
  - Higher out of pocket expenses for insured population.
    - 13% of working age adults spend 10% or more on out-of-pocket costs. (NY Times, 12/1/2014)
    - Patients are “shopping around more... having cost discussions and putting off hip and knee replacements”. David Holte MD, Waconia MN (Wall Street Journal, 12/3/2014)
- Newly insured on a “Learning Curve” (New York Times, 8/2/2014)
  - “It’s not like you enroll and, voila!, you immediately know how to use it. There are a lot of people who really have some big questions about what now?” Rebecca Cashman, Resources for Human Development, Philadelphia PA
Who do physical therapists treat?

Who are Ambulatory, Non- Elderly Adult Therapy Patients? (2011 MEPS Data)

- 6.15 million non-elderly, adult Americans visit an ambulatory OT or PT each year.
  - 3.3% of the U.S. population age 18-64
- 82% of these persons are privately insured.
  - 12% of these persons have public insurance (Medicaid)
  - 6% of these persons are uninsured.
- 78% of these persons are Caucasian.
  - 10% of these persons are Hispanic.
  - 8% of these persons are Black
  - 4% of these persons are Asian.

- 53% of therapy patients are age 50-64
  - 22% of therapy patients are age 18-34
  - 25% of therapy patients are age 35-49
- 48% of therapy patients have high incomes (> 400% FPL)
  - 8.2% of therapy patients are poor (< 100% FPL)
  - 2.6% of therapy patients are near poor (100-125% FPL)
  - 6.4% of therapy patients are low income (125-200% FPL)
Odds of a Therapy Visit for a Black or White Americans with Arthritis, Controlled for Insurance, Income and Level of Education

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds Ratio</th>
<th>Standard Error</th>
<th>T-statistic</th>
<th>p-value</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racebx</td>
<td>1.217748</td>
<td>0.0620677</td>
<td>3.87</td>
<td>0.000</td>
<td>1.101677 - 1.346047</td>
</tr>
<tr>
<td>Povcat</td>
<td>1.07033</td>
<td>0.0363707</td>
<td>2.00</td>
<td>0.046</td>
<td>1.001186 - 1.11425</td>
</tr>
<tr>
<td>Inscov</td>
<td>0.8271441</td>
<td>0.0537934</td>
<td>-2.92</td>
<td>0.004</td>
<td>0.727902 - 0.9399168</td>
</tr>
<tr>
<td>Educyr</td>
<td>1.106529</td>
<td>0.0148579</td>
<td>7.54</td>
<td>0.000</td>
<td>1.077711 - 1.136118</td>
</tr>
<tr>
<td>Constant</td>
<td>0.0128454</td>
<td>0.0035732</td>
<td>-15.66</td>
<td>0.000</td>
<td>0.0074358 - 0.0221906</td>
</tr>
</tbody>
</table>

Ambulatory therapy clinics have largely served an older, privately insured, Caucasian, middle to upper income segment of the U.S. working age population.

The population historically served by physical therapists working in ambulatory environments is not the emerging, newly insured segment of the U.S. population.
Historical affordability barriers are receding.  
But is it “build and they will come?”


Barriers to Access to Health Care

- Kullgren and McLaughlin (2010)
  - Studied health care access in Alameda CA, Austin TX and Southern Maine (2010)
- Financial
  - Affordability - Premiums and Out of Pocket Expenses
- Non-Financial
  - Lack of available providers
  - Inadequate patient knowledge of where and how to seek services
  - Difficulty making appointments
  - Inconvenient hours of service
  - Language barriers and cultural competence
The Joint Arthroplasty Example

- A racial disparity of joint arthroplasty for black Americans with arthritis has been well established.
  - Why?
    - Affordability and...
    - Higher rates of housing segregation impacts access
    - Lower preference for joint surgery in black population.
  - Patients are more risk adverse
    - Increased concerns about pain
    - Lower trust in the health care system
    - Fewer peers in the community have received the procedure
    - Lack of understanding about the procedure.

Physical Therapy Considerations

<table>
<thead>
<tr>
<th>Possible Opportunities</th>
<th>Possible Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of interdisciplinary models of care</td>
<td>Implications for physician-owned physical therapy efforts</td>
</tr>
<tr>
<td>Development of health information technology (EHRs will critical for communication with physicians, hospitals, and others in ACO)</td>
<td>Creation of anti-competitive markets</td>
</tr>
<tr>
<td>PT participation/strategy for value-based purchasing and other quality initiatives (outcomes data)</td>
<td>How does the ACO model fit into current and future PT payment models (i.e. alternatives to outpatient therapy payment)</td>
</tr>
</tbody>
</table>
Ramifications for health care professionals

• Scope of practice could enhance role in patient care
• Medical homes, Accountable Care Organizations and other delivery/payment system reform pilots could support an expanded role in chronic disease management/medication counseling, monitoring, etc.
• Medical loss ratio cap: try to be in the “direct services” portion

Specific citations for non-physician professionals

• Team members for “independence at home medical practice” and “patient-centered medical homes”
• Providers for School-Based Health Centers
• Providers in patient-centered medical homes (community health teams)
• Nurse-managed health care clinics
• Nurse retention grants/career development/health facility decision-making
• Graduate nurse education demonstration project for hospital-based clinical training for advanced practice nurses
• Support for nurse home visitor programs

Solutions to Think About

• Know your market (and your emerging market)
• Do not expect newly insured persons to understand the purpose, benefits and risks of physical therapy (or health care).
  – Establish trust
• Consumers as managers of “marginal utility”
  – What is the value of one more visit?
• Think about all dimensions of access
  – Location and transportation resources
  – Hours of operation and different schedules
  – Cultural competence of staff
References