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Our Vision

Transforming the diverse communities in Maryland to advance health and wellness by optimizing

March 4, 2026

The Honorable Pam Beidle, Chair
Senate Finance Committee
Miller Senate Office Building, Room 3 East
11 Bladen St., Annapolis, MD 21401

RE: Senate Bill 699- SUPPORT

Dear Chair Beidle,

The American Physical Therapy Association Maryland is writing to register our support of **Senate Bill 699 - Health Insurance - Physical Therapy - Copayments, Coinsurance, and Deductibles.**

The purpose of this legislation is to “prohibit insurers, nonprofit health service plans, and health maintenance organizations from imposing a copayment, coinsurance, or deductible for covered physical therapy services that is greater than the copayment, coinsurance, or deductible imposed for an annual physical or wellness visit under the same plan or contract.”

Physical Therapist’s involvement in patient care improves outcomes and reduces cost and strain to the healthcare delivery system.

The Problem:

- Physical therapy frequently requires multiple visits over an extended period of time, as the practice of physical therapy works in conjunction with the healing process.
- Many consumers are forced to pay nearly \$600 per month in out-of-pocket expenses to receive physical therapy services. This is in addition to the cost of health insurance paid by the consumer or their employer.
- Decisions by consumers to reduce the frequency or duration of their care or not to even initiate physical therapy has led to poor outcomes and complications, which only lead to higher costs for health care in the future.

Background:

- Physical Therapists routinely participate with commercial insurance plans.

- Under Maryland law and regulation physical therapists are direct access providers and can bill independently for patient visits.
- Frequently patients encounter challenges with commercial carriers through the imposition of high cost and wide-ranging copay and cost share requirements.
- In some cases, more than 50% of the PT's reimbursement comes not from the insurer but the patient through cost share fees imposed by the insurer.
- This becomes a tremendous financial barrier to care when the patient is asked to pay more out of pocket than what the insurer reimburses the PT.
- High copays can lead to patients managing pain with low-cost opioids, which can lead to dependency and death.
- The result is patients get discouraged to continue receiving the treatment and therapy they need.

The Solution:

- Senate Bill 699 will prohibit insurers from applying a copay, coinsurance or deductible to physical therapist services that is greater than the copay, coinsurance or deductible for a physical or wellness visit.
- This will bring down the high cost of copays confronting patients and prohibiting access to care for patients
- **13 States** have passed legislation similar to the language below to limit the cost of copays. These states include: Arkansas (2013), Connecticut (2013), Delaware (2018), Iowa (2015), Kentucky (2011), Missouri (2013), New Hampshire (2014), New Mexico (2019), Ohio (2024), Pennsylvania (2015), South Dakota (2012), Tennessee (2013), and West Virginia (2023)

The Impact:

- The share of the National health care dollar represented by rehabilitation services (which traditionally includes PT, OT, chiropractor, etc.) is less than 3%. The PT portion of that is significantly smaller.
- In States with copay limits, utilization of PT has increased access to care.
- Studies have shown:
 - Higher levels of copays or cost-sharing often leads to lower utilization of services
 - Physical therapy is a proven, conservative treatment alternative to opioids for chronic pain management

For the reasons noted above we ask for a favorable report on Senate Bill 699.

Sincerely,

Roy Film, PT, DPT
 President, APTA Maryland

ATTACHMENTS:

1. *APTA Maryland research on Copays – Average Frequency of Physical Therapy by Condition*
2. *Cost Effectiveness of Physical Therapy Services across a range of conditions*
3. *APTA MD Response to MHCC/Berry Dunn Study from 2022*
4. *CoPay Statutes in other states*

ATTACHMENT 1:

APTA Maryland Research on Fair Copays Average Frequency of Physical Therapy by Condition (February 2022)

Condition	Recommended Freq/Week	Average Duration	Impact & Goals	Co-Pay Range per Week (\$20-\$80)
Heart Failure	3-5 times/wk	8-12 Weeks	<ul style="list-style-type: none"> ▪ reduce the risk of hospital admissions and readmissions ▪ increase quality of life ▪ improve prognosis ▪ reduce adverse events 	<ul style="list-style-type: none"> ▪ \$60-\$240 if 3 days ▪ \$100-\$400 if 5 days <p>Monthly: \$240-\$960 (3 days/wk) \$400-\$1600 (5 days/wk)</p>
ACL Injury	1-2 times/wk	8-24 Weeks	<ul style="list-style-type: none"> ▪ restore knee function ▪ reduce swelling, ▪ restore mobility, ▪ regain range of motion ▪ Improve overall strength of the quadriceps and hamstring muscles 	<ul style="list-style-type: none"> ▪ \$20-\$80 if 1 day ▪ \$40-\$160 if 2 days <p>Monthly: \$80-\$320 (1 day/wk) \$160-\$640 (2 days/wk)</p>
Lymphedema	3-5 times/wk	6-12 weeks	<ul style="list-style-type: none"> ▪ decrease swelling ▪ reduce risks of infection, ▪ reduce risk of hospitalization ▪ promote independence in the self-management of lymphedema including appropriate compression garments, ▪ improve functional mobility ▪ improve strength and range of motion 	<ul style="list-style-type: none"> ▪ \$60-\$240 if 3 days ▪ \$100-\$400 if 5 days <p>Monthly: \$240-\$960 (3 days/wk) \$400-\$1600 (5 days/wk)</p>
Spinal Cord Injury			<ul style="list-style-type: none"> ▪ Maximizing recovery of motor function ▪ Improved ability and independence with functional activities and walking ▪ Minimizing risk of future injury/medical problems 	
Stroke	2-3 times/wk	12-24 months * For some stroke survivors, rehabilitation will be an ongoing process to maintain and refine skills for years after the stroke	<ul style="list-style-type: none"> ▪ Improve and restore Walking speed ▪ Improve and restore walking distance ▪ Regain overall balance 	<ul style="list-style-type: none"> ▪ \$40-\$160 if 2 days ▪ \$60-\$240 if 3 days

Post-Operative Surgery Physical Therapy - A vital part of recovery

Following surgery, bones, muscles, and soft tissues undergo a period of healing. Failure to use the joint may cause it to heal improperly. This can limit the range of motion, flexibility, function of the joint, and overall surgical outcome. PT post-surgery can also help manage pain levels without excessive use of prescription narcotics.

ATTACHMENT 2:

Our Report Validates the Cost-Effectiveness of Physical Therapist Services Across a Range of Conditions

"The Economic Value of Physical Therapy in the United States" compares the costs and benefits of physical therapist services with other forms of treatment for a variety of health conditions. For each condition, the report demonstrates and validates the cost-effectiveness of physical therapist services, quantifying the average net cost benefit in economic terms. Following our evaluation of these conditions, APTA plans to expand to additional conditions in future reports.



November 17, 2022

Ben Steffen, Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
VIA Email: Ben.steffen@maryland.gov

RE: Comments regarding Berry Dunn Report: “Health Insurance Cost Sharing – Physical Therapy Parity with Primary Care Services – House Bill 974 and Senate Bill 725”

Dear Mr. Steffen and Commissioners,

Thank you for the opportunity to review the report prepared by Berry Dunn as requested by the House of Delegates and Senate of Maryland. We appreciated the opportunity to meet with your team and the Berry Dunn team to learn more about the aim of the report and to provide studies and resources for the Berry Dunn team to review and consider. Upon reading the report we offer the following comments and reactions for your consideration and response.

Addressing copay costs is an important policy consideration as the health care system in Maryland continues to emphasize treatment of chronic conditions and disease states in the community and outside the hospital setting. When copays paid by patients exceed and/or cover the carrier’s allowed amount, the patient is paying for this medical service essentially out of pocket. This creates an unfavorable balance for the patient and the PT provider.

Cost:

The report states that should legislation be enacted in 2024, it would result in an estimated cost increase of between “\$0.17 to \$0.28 PMPM inclusive of medical trends and employer benefit changes.” This increase to subscribers would result as the carriers work to shift those costs from patient copays to patient premiums. When considering the law would only apply to roughly 18% of the insured in Maryland, high-end projections approach a total increase of \$1.6 million/year. This amount is far below the higher cost projections noted by the carriers during testimony on the bill. In fact, it is lower than the revised fiscal note estimates provided by the Department of Legislative Services, which reduced projected costs from \$47 million to \$7million/year.

Patient Experience:

The Berry Dunn report touches on but did not go into enough detail or provide a description of the typical PT patient experience. This is an important element to the discussion at hand. PT patients may require multiple visits during an acute course of care, pre and post-surgical care, or long term management. Copays for PT visits add up in ways that other medical copay costs do not. A few case examples illustrating this would be helpful for the policy makers who read this report. For instance, a patient with a \$50 copay who sees a physical therapist twice a week for 8 weeks following a total knee surgery would end up paying \$800. Patients with low back pain who see a physical therapist 7 times, on average, would pay \$350 in total. This has been cited as a driver of opioid use as the one-time copay for medication is often \$10-20. High copayment costs for physical therapy services, while intended to discourage the irresponsible overutilization of health resources, in this case may have the unintended consequence of driving the use of opioids as has been discussed in published health services research. This is known to

have an outsized impact on less affluent patients and, as a result, significantly limits their access to care despite having insurance coverage.

Patient demand and satisfaction:

We are pleased to see that Berry Dunn did note throughout the report the high levels of efficacy, safety, and patient satisfaction with regard to PT providers and services. The report specifically emphasized the importance of PT services in treating Covid-19 patients in treating and managing their symptoms and conditions. As Maryland’s population trends toward an older and senior population, the need for PT services is expected to increase. Copays and premiums aside, the demand will be there, and as a profession PTs have been growing in numbers across the country to meet this demand. As some in the population age into Medicare coverage, a significant number are likely to continue to rely on commercial insurance as primary or secondary coverage. Patient access to PT care will continue to grow in importance.

Experience in other states:

The report did not go as far as was anticipated with regard to experience in other states. APTA MD has been reaching out to our national affiliate and fellow state components for experience. We have not heard that premiums have increased or that insurance markets have become destabilized as a result of copay limitations. That is invaluable information that can help ease concerns and provide measurable impacts. It would be helpful for the Berry Dunn team to note any outreach regarding other state experiences outside of the APTA information noted in the end notes.

Carrier Input:

It would be helpful as well to see in an appendix the survey questions posed to the carriers, which carriers were approached, and if possible, from whom responses were received. The report notes feedback from carriers proposing a range of policy responses from doing nothing to raising premiums or restructuring benefits through visit limits and additional preauthorization requirements. When the goal of this legislation is to reduce/remove barriers, it is disheartening to see contemplation of new more challenging barriers being imposed. The report states how carriers have worked to keep premiums low in recent years through the use of deductibles and copays. While the lower premiums are attractive and beneficial on the front end, the types of care and services that fall under high deductibles and copays make medical care decision making one of affordability more than one based on medical need and benefit.

APTA MD appreciates Berry Dunn’s investigation of this important issue and thanks the MHCC for this opportunity to provide written comments. We stand ready to provide additional information and respond to any questions from the Commission.

Respectfully submitted,



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PT CoPAY STATUTES IN OTHER STATES

SUMMARY CHART

STATE	DATE EFFECTIVE	BASIS OF CoPAY CALCULATION (FULL TEXT OF PROVISIONS NOTED IN CHART BELOW)
1. Arkansas	2013	No greater than Primary Care visit
2. Connecticut	2015	Maximum \$30
3. Delaware	2018	Equal to or less than 25% of the fee due or to be paid to the physical therapist
4. Iowa	2015	No greater than a Physician or Surgeon office visit
5. Kentucky	2011	No greater than a Physician or Surgeon office visit
6. Missouri	2013	No greater than Primary Care visit
7. New Hampshire	2014	No greater than Primary Care visit
8. New Mexico	2019	No greater than Primary Care visit
9. Ohio	2025	No greater than Primary Care visit
10. Pennsylvania	2015	Only one copayment per visit when seeing multiple rehab professionals (PT, OT, Chiro)
11. South Dakota	2012	No greater than Primary Care or other Physician office visit
12. Tennessee	2013	No greater than Primary Care visit
13. West Virginia	2023	No greater than Primary Care visit

CURRENT AND RECENT EFFORTS IN OTHER STATES

State	Proposed Legislation	Key Provision/Functional Language
Rhode Island	<u>2026-H 7429</u> (active)	(a) An individual or group health insurance plan or policy delivered, issued for delivery, or renewed in this state on or after January 1, 2027, shall not impose a copayment, coinsurance, or office visit deductible amount charged to the insured for services rendered by a physical therapist licensed under § 5-40-7 that is greater than the copayment, coinsurance or office visit deductible amount charged to the insured for the services of a primary care physician or osteopath licensed under chapter 37 of title 5.
New York	<u>Senate Bill S5045A</u> (active)	Provides that any copayment or coinsurance amount charged by an insurer to the insured for services rendered by a physical therapist or an occupational therapist shall not be more than twenty-five percent greater than the copayment or coinsurance amount imposed for an office visit to a licensed primary care physician or osteopath for the same or a similar diagnosed condition.
Texas	<u>H.B. No. 3695</u> (not active)	A health care plan that requires an enrollee to pay a copayment for an office visit with the enrollee's primary care physician or provider may not charge a higher copayment amount to that enrollee for an office visit with a physical therapist if that visit did not require a referral from a physician or provider.

STATE STATUTES IN EFFECT

State	Statute
Arkansas (2013)	<p>Universal Citation: AR Code § 23-79-157 (2024)</p> <p>(a) As used in this section:</p> <p>(1)</p> <p>(A) "Health benefit plan" means any group or blanket plan, policy, or contract for healthcare services issued or delivered in this state by healthcare insurers, including indemnity and managed care plans and the plans providing health benefits to state and public school employees under § 21-5-401 et seq., but excluding individual major medical plans and plans providing healthcare services under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.</p> <p>(B) "Health benefit plan" does not include an accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policy;</p> <p>(2) "Healthcare insurer" means any insurance company, hospital and medical service corporation, or health maintenance organization issuing or delivering health benefit plans in this state and subject to any of the following laws:</p> <p>(A) The insurance laws of this state;</p> <p>(B) Section 23-75-101 et seq., pertaining to hospital and medical service corporations; and</p> <p>(C) Section 23-76-101 et seq., pertaining to health maintenance organizations;</p> <p>(3) "Licensed physical therapist, occupational therapist, or speech-language pathologist" means:</p> <p>(A) A physical therapist licensed under §§ 17-93-101 - 17-93-312;</p> <p>(B) An occupational therapist licensed under the Arkansas Occupational Therapy Practice Act, § 17-88-101 et seq.; and</p> <p>(C) A speech-language pathologist licensed under §§ 17-100-102 - 17-100-308; and</p> <p>(4) "Licensed primary care physician or osteopath" means a primary care physician and an osteopath licensed under §§ 17-80-101 - 17-95-505.</p> <p>(b) An insurer shall not impose a copayment, coinsurance, or an office visit deductible amount or a combination of a copayment, coinsurance, or an office visit deductible amount charged to the insured for services rendered for a date of service by a licensed physical therapist, occupational therapist, or speech-language pathologist that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for an office visit for the service of a licensed primary care physician or osteopath.</p>

State	Statute
	<p>(c) An insurer shall state in its health benefit plan:</p> <ul style="list-style-type: none"> (1) The availability of physical therapy, occupational therapy, or speech-language pathologist coverage under its plan; and (2) All related limitations, conditions, and exclusions. <p>Added by Act 2013, No. 342, § 1, eff. 8/16/2013.</p>
<p>Connecticut (2013, 2024)</p>	<p>CT Gen Stat § 38a-511a. (2024)</p> <p>No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall impose copayments that exceed a maximum of thirty dollars per visit for in-network (1) physical therapy services rendered by a physical therapist licensed under section 20-73, or (2) occupational therapy services rendered by an occupational therapist licensed under section 20-74b or 20-74c. The provisions of this section shall not apply to a copayment-only health plan as that term is used in subsection (c) of section 38a-511.</p> <p>(P.A. 13-307, S. 1; P.A. 14-97, S. 3; P.A. 24-81, S. 102.)</p> <p>History: P.A. 13-307 effective January 1, 2015; P.A. 14-97 designated existing provisions re copayment limit for physical therapy services as Subdiv. (1) and added Subdiv. (2) re copayment limit for occupational therapy services, effective January 1, 2015; P.A. 24-81 provides that provisions of this section shall not apply to copayment-only health plans, effective January 1, 2025.</p> <p>See Sec. 38a-550a for similar provisions re group policies.</p>
<p>Delaware (2018)</p>	<p>24 DE Code § 2621 (2024)</p> <p>§ 2621. Physical therapists eligible for compensation from insurance.</p>

State	Statute
	<p>(a) For purposes of disability insurance, standard health and accident, sickness, and all other such insurance plans, whether or not they are considered insurance policies, and contracts issued by health service corporations and health maintenance organizations, if a physical therapist is authorized by law to perform a particular service, the physical therapist is entitled to compensation for that physical therapist's services under such plans and contracts, and such plans and contracts may not have annual or lifetime numerical limits on physical therapy visits for the treatment of back pain.</p> <p>(b) Nothing in this section prevents the operation of reasonable and nondiscriminatory cost containment or managed care provisions, including deductibles, coinsurance, allowable charge limitations, coordination of benefits, and utilization review. Any copayment or coinsurance amount must be equal to or less than 25% of the fee due or to be paid to the physical therapist under the policy, contract, or certificate for the treatment, therapy, or service provided.</p> <p>(c) The Insurance Commissioner shall issue and administer regulations to aid the administration, effectuation, investigation, and enforcement of this section. 81 Del. Laws, c. 430, § 3;</p>
<p>Iowa (2015)</p>	<p>514C.30 Services provided by a physical therapist, occupational therapist, or speech pathologist.</p> <p>1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses shall not impose a copayment or coinsurance amount on an insured for services provided by a physical therapist licensed pursuant to chapter 148A, by an occupational therapist licensed pursuant to chapter 148B, or by a speech pathologist licensed pursuant to chapter 154F that is greater than the copayment or coinsurance amount imposed on the insured for services provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery under chapter 148 for the same or a similar diagnosed condition even if a different nomenclature is used to describe the condition for which the services are provided.</p> <p>2. This section applies to the following classes of third-party payment provider policies, contracts, or plans delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2015:</p> <ul style="list-style-type: none"> a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis. b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

State	Statute
	<p>c. An individual or group health maintenance organization contract regulated under chapter 514B. d. A plan established pursuant to chapter 509A for public employees.</p> <p>3. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.</p> <p>2015 Acts, ch 137, §101, 162, 163; 2017 Acts, ch 148, §82</p>
<p>Kentucky (2011)</p>	<p>KY Rev Stat § 304.17A-177 (2024)</p> <p>304.17A-177 Limitation on amount of copayment or coinsurance charged for services rendered by occupational or physical therapist --Insurer to clearly state coverage.</p> <p>(1) An insurer shall not impose a copayment or coinsurance amount charged to the insured for services rendered for each date of service by an occupational therapist licensed under KRS Chapter 319A or a physical therapist licensed under KRS Chapter 327 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 an office visit.</p> <p>(2) An insurer shall state clearly the availability of occupational and physical therapy coverage under its plan and all related limitations, conditions, and exclusions.</p> <p>Effective: June 8, 2011 History: Created 2011 Ky. Acts ch. 92, sec. 1, effective June 8, 2011.</p>

State	Statute
<p>Missouri (2013)</p>	<p>376.1235. No co-payments or coinsurance for physical or occupational therapy services, when — actuarial analysis of cost, when. —</p> <p>1. No health carrier or health benefit plan, as defined in section 376.1350, shall impose a co-payment or coinsurance percentage charged to the insured for services rendered for each date of service by a physical therapist licensed under chapter 334 or an occupational therapist licensed under chapter 324, for services that require a prescription, that is greater than the co-payment or coinsurance percentage charged to the insured for the services of a primary care physician licensed under chapter 334 for an office visit.</p> <p>2. A health carrier or health benefit plan shall clearly state the availability of physical therapy and occupational therapy coverage under its plan and all related limitations, conditions, and exclusions.</p> <p>3. Beginning September 1, 2016, the oversight division of the joint committee on legislative research shall perform an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if the provisions of this section regarding occupational therapy coverage were enacted. By December 31, 2016, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker, the president pro tem, and the chairpersons of both the house of representatives and senate standing committees having jurisdiction over health insurance matters. If the fiscal note cost estimation is less than the cost of an actuarial analysis, the actuarial analysis requirement shall be waived.</p> <p>----- (L. 2013 S.B. 159, A.L. 2016 S.B. 608 merged with S.B. 635) Effective 8-28-16 (S.B. 635); *10-14-16 (S.B. 608), see § 21.250</p>
<p>New Hampshire (2014)</p>	<p>NH Rev Stat § 415:6-s (2015)</p> <p>[RSA 415:6-s effective as provided in 2014, 299:5, and repealed by 2014, 299:8, I, effective October 1, 2017.]</p> <p>415:6-s Copayments, Coinsurance, or Office Visit Deductibles for Certain Providers. –</p> <p>I. Each insurer that issues or renews any 2014 Patient Protection and Affordable Care Act of 2009, Public Law 111-148--compliant individual policy, plan, or contract of accident or health insurance that constitutes health coverage for the services of chiropractors licensed under RSA 316-A, or physical</p>

State	Statute
	<p>therapists licensed under RSA 328-A, shall not charge a copayment, coinsurance, or office visit deductible that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for the services of a primary care physician licensed under RSA 329.</p> <p>II. The commissioner shall compile available data and prepare reports concerning member cost sharing and the impact on utilization of services for physical therapy and chiropractic care. The first report shall be due by December 1, 2014, and shall analyze all New Hampshire insurance markets and identify differences in cost sharing and utilization of health services for the purpose of determining if there is a statistical association between the use of physical therapy and chiropractic care services and copayment amounts. The commissioner shall also seek to determine whether the overall costs of patients that utilize chiropractic care or physical therapists are less when the patient has lower copayment amounts for these services, and if any observed lower overall patient costs are caused by reductions in other health care services and better health care outcomes, not patient health status.</p> <p>III. A second report shall be due October 1, 2017, with requirements to provide the same information, but using the most current data available.</p> <p>IV. The insurance department shall consult with providers in preparing the scope of this study and gathering research for the study. Data shall include, but not be limited to, the costs for all physician services, medication, imaging, hospitalization, and procedures, such as spinal injections. For purposes of ensuring a more complete comparison, the top 50 ICD codes for diagnosis treated by physical therapists and chiropractors shall be analyzed and a comparison of the total cost of low copay plans and high copay plans shall be conducted.</p> <p>V. The commissioner shall make the reports, together with any recommendations for legislation, to the president of the senate, the speaker of the house of representatives, the governor, and the chairs of the house and senate commerce committees.</p> <p>Source. 2014, 299:1, eff. as provided in 2014, 299:5.</p>

State	Statute
<p>New Mexico (2019)</p>	<p>NM Stat § 59A-22-56 (2024)</p> <p>A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall not impose a member cost share for physical rehabilitation services that is greater than that for primary care services on a coinsurance percentage basis when coinsurance is applied or on an absolute dollar amount when a copay is applied.</p> <p>B. As used in this section:</p> <p>(1) "physical rehabilitation services" means services aimed at maximizing an individual's level of function, returning to a prior level of function or maintaining or slowing the decline of function, which services are provided by or under the direction of a licensed physical therapist, occupational therapist or speech therapist; and</p> <p>(2) "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.</p> <p>History: Laws 2019, ch. 188, § 2. ANNOTATIONS Effective dates. — Laws 2019, ch. 188, § 6 made Laws 2019, ch. 188 effective January 1, 2020.</p>
<p>Ohio (2025)</p>	<p>Sec. 3902.63. (A) On and after the effective date of this section, and notwithstanding section 3901.71 of the Revised Code, the cost-sharing requirement, on a per day basis, imposed by a health benefit plan for services rendered by an occupational therapist or physical therapist licensed under Chapter 4755. of the Revised Code or a chiropractor licensed under Chapter 4734. of the Revised Code shall not be greater than the cost-sharing requirement imposed by the plan for an office visit to a primary care physician or primary care 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 H. B. No. 141 Page 2 As Passed by the House osteopath physician licensed pursuant to Chapter 4731. of the Revised Code.</p>

State	Statute
<p>Pennsylvania (2015)</p>	<p>Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding an article to read: 2015 Act 39 ARTICLE X-B. FAIRNESS IN MULTIPLE COPAYMENTS.</p> <p>Section 1001-B. Declaration of intent. The general purpose of this article is to provide fairness for persons seeking medically necessary physical therapy, chiropractic and occupational therapy who are sharing the cost of the care pursuant to a health insurance policy by prohibiting the imposition of multiple copayments for licensed physical therapy, chiropractic and occupational therapy services.</p> <p>Section 1002-B. Definitions. The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise: "Chiropractic." As defined in section 102 of the act of December 16, 1986 (P.L.1646, No.188), known as the Chiropractic Practice Act. "Copayment." A specific dollar amount a covered person must pay for services rendered by a provider under a health benefit plan. "Health insurance policy." As follows: (1) An individual or group health insurance policy, contract or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered by or is governed under any of the following: (i) This act. (ii) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act. (iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations). (iv) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations). (2) The term does not include accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.</p>

State	Statute
	<p>"Occupational therapy." As defined in section 3 of the act of June 15, 1982 (P.L.502, No.140), known as the Occupational Therapy Practice Act.</p> <p>"Physical therapy." As defined in section 2 of the act of October 10, 1975 (P.L.383, No.110), known as the Physical Therapy Practice Act.</p> <p>Section 1003-B. Limits on copayments. A health insurance policy that is delivered, issued for delivery, renewed, extended or modified in this Commonwealth by a health care insurer for services provided by a licensed physical therapist, chiropractor or occupational therapist provider may not subject an insured to more than one copayment amount per visit or deplete more than one visit with any one provider.</p> <p>Section 1004-B. Regulations. The department may promulgate regulations as may be necessary or appropriate to carry out the provisions of this article.</p> <p>Section 1005-B. Penalties. A violation of this article by an insurer if committed flagrantly and in conscious disregard of the provisions of this article or with frequency sufficient to constitute a general business practice shall be considered a violation of the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act. A violation of this article is deemed an unfair method of competition and an unfair deceptive act or practice pursuant to the Unfair Insurance Practices Act.</p> <p>Section 1006-B. Applicability. This article shall apply as follows: (1) For health insurance policies for which either rates or forms are required to be filed with the Federal Government or the Insurance Department, this article shall apply to any policy for which a form or rate is first filed on or after the effective date of this section. (2) For health insurance policies for which neither rates nor forms are required to be filed with the Federal Government or the Insurance Department, this article shall apply to any policy issued or renewed on or after 180 days after the effective date of this section.</p>

State	Statute
<p>South Dakota (2012)</p>	<p><u>58-17-54.1</u>. Copayment or coinsurance amounts for chiropractic, physical therapy, or occupational therapy services.</p> <p>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 <u>36-5</u>, an occupational therapist licensed pursuant to chapter <u>36-31</u>, or a physical therapist licensed pursuant to chapter <u>36-10</u> 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.</p> <p>Source: SL 2011, ch 217, § 1; SL 2012, ch 244, § 1.</p>
<p>Tennessee (2013)</p>	<p>TN Code § 56-7-2409 (2024)</p> <p>(a) As used in this section:</p> <ol style="list-style-type: none"> (1) "Coinsurance" means a percentage of the contractual fee schedule applicable to a particular health care provider that a covered person must pay for covered services rendered by that provider under the terms of a particular health insurance policy or plan; (2) "Copayment" means the specified dollar amount that a covered person must pay for covered services during a visit to a health care provider under the terms of a particular health insurance policy or plan; (3) "Covered person" has the same meaning as set forth in § 56-7-110(a); and (4) "Health insurance entity" has the same meaning as set forth in § 56-7-109, but does not include government insurance plans created by title 8, chapter 27. <p>(b) A health insurance entity offering employer-based plans must offer to employers no less than one (1) plan option in which the copayment and coinsurance amounts for services rendered during an office visit to a chiropractic physician licensed under title 63, chapter 4, or to a physical therapist or occupational therapist licensed under title 63, chapter 13, are no greater than the copayment and coinsurance amounts for the services rendered during an office visit to a primary care physician licensed under title 63, chapter 6 or title 63, chapter 9.</p> <p>(c) Compliance with this section shall not be required with respect to a particular insurance plan if it is determined that compliance would cause that plan to lose its status as a grandfathered health plan within the meaning of § 1251 of the federal Patient Protection and Affordable Care Act, P.L. 111-148, as</p>

State	Statute
	<p>amended, and § 2301 of the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, as amended, both compiled in 42 U.S.C. § 18011.</p> <p>(d) Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care, or other limited benefit hospital insurance policies, and any employer plan exempt from regulation under this title due to § 514 of the federal Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1144).</p> <p><i>Amended by 2014 Tenn. Acts, ch. 862, s 1, eff. 1/1/2015.</i></p>
<p>West Virginia (2023)</p>	<p>CHAPTER 33. INSURANCE. ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE. <u>§33-15-23.</u> Copayments for certain services.</p> <p>(a) A policy, provision, contract, plan, or agreement subject to this article may not impose a copayment, coinsurance, or office visit deductible amount charged to the insured for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-language pathologist assistant, licensed physical therapist, or a licensed physical therapist assistant that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for the services of a primary care physician or an osteopathic physician.</p> <p>(b) The policy, provision, contract, plan, or agreement shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.</p> <p>ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE. <u>§33-16-19.</u> Copayments for certain services.</p> <p>(a) A group health plan, health benefit plan or network plan subject to this article may not impose a copayment, coinsurance, or office visit deductible amount charged to the insured for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-language pathologist assistant, licensed physical therapist, or a licensed physical therapist assistant that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for the services of a primary care physician or an osteopathic physician.</p>

State	Statute
	<p>(b) The group health plan, health benefit plan or network plan shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.</p> <p>ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS. <u>§33-24-7x. Copayments for certain services.</u></p> <p>(a) A policy, provision, contract, plan, or agreement subject to this article may not impose a copayment, coinsurance, or office visit deductible amount charged to a subscriber for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-language pathologist assistant, licensed physical therapist, or a licensed physical therapist assistant that is greater than the copayment, coinsurance, or office visit deductible amount charged to the subscriber for the services of a primary care physician or an osteopathic physician.</p> <p>(b) The policy, provision, contract, plan, or agreement shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.</p> <p>ARTICLE 25. HEALTH CARE CORPORATIONS. <u>§33-25-8u. Copayments for certain services.</u></p> <p>(a) A policy, provision, contract, plan, or agreement subject to this article may not impose a copayment, coinsurance, or office visit deductible amount charged to a subscriber or member for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-language pathologist assistant, licensed physical therapist, or a licensed physical therapist assistant that is greater than the copayment, coinsurance, or office visit deductible amount charged to the subscriber or member for the services of a primary care physician or an osteopathic physician.</p> <p>(b) The policy, provision, contract, plan, or agreement shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.</p> <p>ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT. <u>§33-25A-8x. Copayments for certain services.</u></p>

State	Statute
	<p>(a) A health maintenance organization issuing coverage in this state pursuant to the provisions of this article may not impose a copayment, coinsurance, or office visit deductible amount charged to a subscriber or member for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-pathologist assistant, licensed physical therapist, or a licensed physical therapist assistant that is greater than the copayment, coinsurance, or office visit deductible amount charged to the subscriber or member for the services of a primary care physician or an osteopathic physician.</p> <p>(b) The policy, provision, contract, plan, or agreement subject to this article shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.</p> <p>The Clerk of the House of Delegates and the Clerk of the Senate hereby certify that the foregoing bill is correctly enrolled.</p>