SB0699 Health Insurance - Physical Therapy - Copay

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TESTIMONY FOR SB0699 – Health Insurance – Physical Therapy – Copayments, Coinsurance, and Deductibles – FAVORABLE

Bill Sponsor: Senator Klausmeier
Committee: Senate Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Jessica Gorski, Executive Committee
Position: FAVORABLE

Chair, Vice Chair, and Members of the Committee,

My name is Jessica Gorski, and I am submitting this testimony in strong support of SB0699 on behalf of the Maryland Legislative Coalition. We are a coalition of grassroots activist organizations across Maryland, representing more than 30,000 Marylanders in every legislative district. Our mission is to promote legislation in areas such as education, the environment, public safety, healthcare, and social justice that support all Marylanders and improve their lives. We put the power of the people to work in shaping legislation in Maryland.

SB0699 is a practical and necessary step to make medically necessary physical therapy more affordable and accessible for Marylanders.

This bill prohibits insurers, nonprofit health service plans, and health maintenance organizations from imposing a copayment, coinsurance, or deductible for covered physical therapy services that exceeds the cost-sharing required for an annual physical or wellness visit. It also requires plans to clearly state coverage requirements, limitations, conditions, and exclusions for physical therapy services.

For many patients, physical therapy is not optional. It is a critical part of recovery after surgery or injury, an essential tool for managing chronic conditions, and a proven method for preventing long-term disability. When cost-sharing for physical therapy is significantly higher than for routine care, patients may delay or forgo treatment altogether. This leads to worse health outcomes, higher long-term medical costs, and avoidable strain on families and caregivers.

It is also important to recognize that medical costs are the leading cause of personal bankruptcy in the United States, and Maryland is no exception. High out-of-pocket expenses force many families to choose between essential care and financial stability. Reducing cost barriers to necessary physical therapy helps prevent Marylanders from falling into medical debt or facing an economic crisis simply for following their doctor's treatment plan.

By aligning cost-sharing for physical therapy with that of annual physicals and wellness visits, SB0699 helps ensure that patients can access the care their providers recommend. Clear, predictable coverage rules also reduce confusion for patients and providers, supporting better continuity of care and more effective treatment plans.

This legislation directly supports the mission of the Maryland Legislative Coalition. It strengthens healthcare access, promotes public health, and advances social justice by reducing financial barriers that disproportionately affect low- and moderate-income Marylanders and those with ongoing medical needs. Making essential rehabilitative care more affordable is a concrete way to improve quality of life and support better long-term outcomes for individuals and communities across the state.

I appreciate your consideration. **We respectfully urge a FAVORABLE report on SB0699.**

2026 APTA MD - Support - Senate Bill 699 - Fair Co

Uploaded by: Daniel Shattuck

Position: FAV

APTA Maryland

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	▪ reduce the risk of hospital admissions and readmissions ▪ increase quality of life ▪ improve prognosis ▪ reduce adverse events	▪ $60-$240 if 3 days ▪ $100-$400 if 5 days **Monthly:** $240-$960 (3 days/wk) $400-$1600 (5 days/wk)
ACL Injury	1-2 times/wk	8-24 Weeks	▪ restore knee function ▪ reduce swelling, ▪ restore mobility, ▪ regain range of motion ▪ Improve overall strength of the quadriceps and hamstring muscles	▪ $20-$80 if 1 day ▪ $40-$160 if 2 days **Monthly:** $80-$320 (1 day/wk) $160-$640 (2 days/wk)
Lymphedema	3-5 times/wk	6-12 weeks	▪ 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	▪ $60-$240 if 3 days ▪ $100-$400 if 5 days **Monthly:** $240-$960 (3 days/wk) $400-$1600 (5 days/wk)
Spinal Cord Injury			▪ 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	▪ **Improve and restore Walking speed** ▪ **Improve and restore walking distance** ▪ **Regain overall balance**	▪ $40-$160 if 2 days ▪ $60-$240 if 3 days

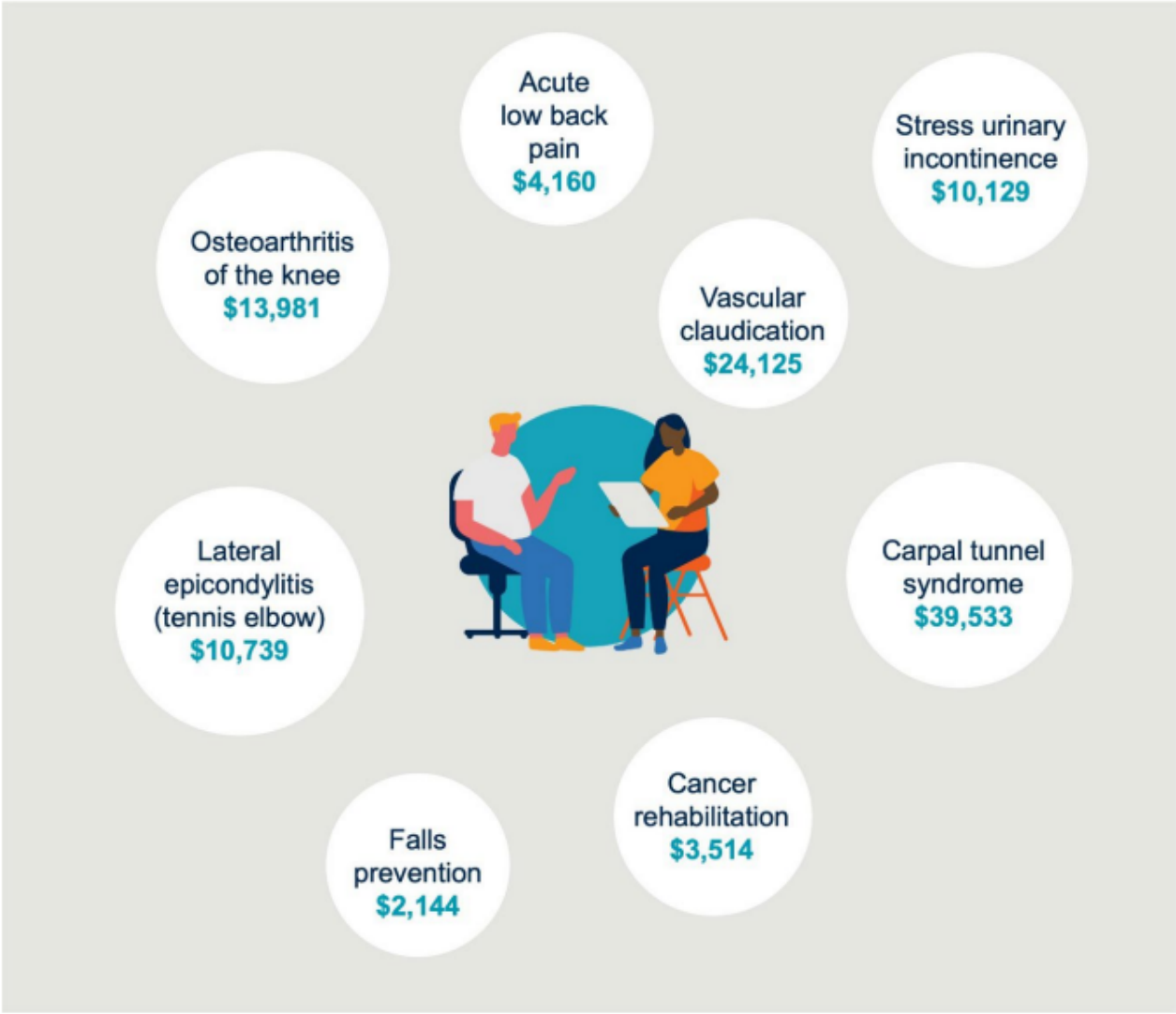
Post-Operative Surgery Physical Therapy - A vital part of recovery

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,

JD Sheppard II, PT, DPT
President
APTA Maryland
jdsheppardii@gmail.com

Roy Film, PT, MPT, DPT
Vice President
APTA Maryland
RFilm@som.umaryland.edu

Lauri Jacobson, MSW
Executive Director
APTA Maryland
aptamd@aptamd.org

Linda Horn, PT, DScPT, MHS
Chief Delegate
APTA Maryland
lhorn@som.umaryland.edu

CC. Barbara Brocato & Dan Shattuck APTA MD Lobbyists – barbara@bmbassoc.com

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	**2026-H 7429** **(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	**Senate Bill S5045A** **(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	H.B. No. 3695 **(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)	**Universal Citation:** AR Code § 23-79-157 (2024) **(a)** As used in this section: **(1)** **(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. **(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; **(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: **(A)** The insurance laws of this state; **(B)** Section 23-75-101 et seq., pertaining to hospital and medical service corporations; and **(C)** Section 23-76-101 et seq., pertaining to health maintenance organizations; **(3)** "Licensed physical therapist, occupational therapist, or speech-language pathologist" means: **(A)** A physical therapist licensed under §§ 17-93-101 - 17-93-312; **(B)** An occupational therapist licensed under the Arkansas Occupational Therapy Practice Act, § 17-88-101 et seq.; and **(C)** A speech-language pathologist licensed under §§ 17-100-102 - 17-100-308; and **(4)** "Licensed primary care physician or osteopath" means a primary care physician and an osteopath licensed under §§ 17-80-101 - 17-95-505. **(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.**

State	Statute
	(c) An insurer shall state in its health benefit plan: **(1)** The availability of physical therapy, occupational therapy, or speech-language pathologist coverage under its plan; and **(2)** All related limitations, conditions, and exclusions. ***Added by Act 2013, No. 342,§ 1, eff. 8/16/2013.***
Connecticut (2013, 2024)	**CT Gen Stat § 38a-511a. (2024)** **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.A. 13-307, S. 1; P.A. 14-97, S. 3; P.A. 24-81, S. 102.) 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. See Sec. 38a-550a for similar provisions re group policies.
Delaware (2018)	**24 DE Code § 2621 (2024)** § 2621. Physical therapists eligible for compensation from insurance.

State	Statute
	(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. **(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.** (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;
Iowa (2015)	**514C.30 Services provided by a physical therapist, occupational therapist, or speech pathologist.** 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.** 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: 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
	c. An individual or group health maintenance organization contract regulated under chapter 514B. d. A plan established pursuant to chapter 509A for public employees. 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. 2015 Acts, ch 137, §101, 162, 163; 2017 Acts, ch 148, §82
Kentucky (2011)	**KY Rev Stat § 304.17A-177 (2024)** 304.17A-177 Limitation on amount of copayment or coinsurance charged for services rendered by occupational or physical therapist --Insurer to clearly state coverage. **(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.** (2) An insurer shall state clearly the availability of occupational and physical therapy coverage under its plan and all related limitations, conditions, and exclusions. Effective: June 8, 2011 History: Created 2011 Ky. Acts ch. 92, sec. 1, effective June 8, 2011.

State	Statute
Missouri (2013)	**376.1235. No co-payments or coinsurance for physical or occupational therapy services, when — actuarial analysis of cost, when. —** **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.** 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. 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. --- (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
New Hampshire (2014)	**NH Rev Stat § 415:6-s (2015)** [RSA 415:6-s effective as provided in 2014, 299:5, and repealed by 2014, 299:8, I, effective October 1, 2017.] **415:6-s Copayments, Coinsurance, or Office Visit Deductibles for Certain Providers. –** **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**

State	Statute
	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. 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. III. A second report shall be due October 1, 2017, with requirements to provide the same information, but using the most current data available. 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. 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. **Source.** 2014, 299:1, eff. as provided in 2014, 299:5.

State	Statute
New Mexico (2019)	**NM Stat § 59A-22-56 (2024)** **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.** B. As used in this section: (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 (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. History: Laws 2019, ch. 188, § 2. ANNOTATIONS Effective dates. — Laws 2019, ch. 188, § 6 made Laws 2019, ch. 188 effective January 1, 2020.
Ohio (2025)	**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.**

State	Statute
Pennsylvania (2015)	**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. 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. 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.

State	Statute
	"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. "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. 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. Section 1004-B. Regulations. The department may promulgate regulations as may be necessary or appropriate to carry out the provisions of this article. 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. 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.

State	Statute
South Dakota (2012)	**58-17-54.1. 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.** Source: SL 2011, ch 217, § 1; SL 2012, ch 244, § 1.
Tennessee (2013)	**TN Code § 56-7-2409 (2024)** (a) As used in this section: (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. **(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.** (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

State	Statute
	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. (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). ***Amended by 2014 Tenn. Acts, ch. 862, s 1, eff. 1/1/2015.***
West Virginia (2023)	**CHAPTER 33. INSURANCE.** **ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.** **§33-15-23. Copayments for certain services.** **(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.** (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. **ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.** **§33-16-19. Copayments for certain services.** **(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.**

State	Statute
	(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. **ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.** **§33-24-7x. Copayments for certain services.** **(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.** (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. **ARTICLE 25. HEALTH CARE CORPORATIONS.** **§33-25-8u. Copayments for certain services.** **(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.** (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. **ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.** **§33-25A-8x. Copayments for certain services.**

State	Statute
	(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. (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. The Clerk of the House of Delegates and the Clerk of the Senate hereby certify that the foregoing bill is correctly enrolled.

economic_value_pt_u.s._report_from_apta-policy_pap
Uploaded by: Linda Horn
Position: FAV

Informing Health Care Policy for Better Outcomes and Cost-Effective Care

Highlights of the American Physical Therapy Association Report "The Economic Value of Physical Therapy in the United States"

September 2023

The Cost-Effectiveness of Physical Therapist Services

The newly released report from the American Physical Therapy Association showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. “The Economic Value of Physical Therapy in the United States” compares physical therapy with non-PT based care across a suite of health conditions commonly seen within the U.S. health care system.

Physical therapists and physical therapist assistants play an important role in the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants as part of multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs.

“The Economic Value of Physical Therapy” aims to objectively inform broader health policy decision making. Policymakers and commercial payers should consider the insights provided in this report to support access to, coverage of, and payment for physical therapist services. Policies that position physical therapists as entry-point providers will ensure beneficiaries have timely access to proven, cost-effective care.

APTA: Supporting the Role of Physical Therapists and Physical Therapist Assistants in the U.S. Health Care System

APTA represents more than 100,000 physical therapists, physical therapist assistants, and students of physical therapy nationwide. We aim to enhance societal health through our mission: building a community that advances the profession of physical therapy. Physical therapists are movement experts who help to optimize physical function, movement, performance, health, quality of life, and well-being of the individuals they engage with.

As of 2016, all physical therapists must receive a doctor of physical therapy degree from an accredited physical therapist education program before taking and passing a national licensure exam that permits them to practice. Licensure is required in each state (or other jurisdiction, including the District of Columbia, Puerto Rico, and the U.S. Virgin Islands) in which a physical therapist practices. Physical therapist assistants must complete a two-year associate degree from an accredited physical therapist assistant program and pass a national exam. State licensure or certification is required in each state (or jurisdiction) in which a physical therapist assistant works.

Physical therapists play an important role in managing a wide range of diagnoses and conditions, mitigating risk for adverse events, and promoting overall wellness. The demand for physical therapist services is increasing in the United States, with more than 300 million Americans seeking physical therapist services each year (“Physical Therapists Industry in the US — Market Research Report,” IBISWorld, 2022).

Despite rising demand, patients face barriers to receiving the physical therapist services they need. Costly copays, declining payment rates, and increased administrative burden all impact patient access to physical therapist services.

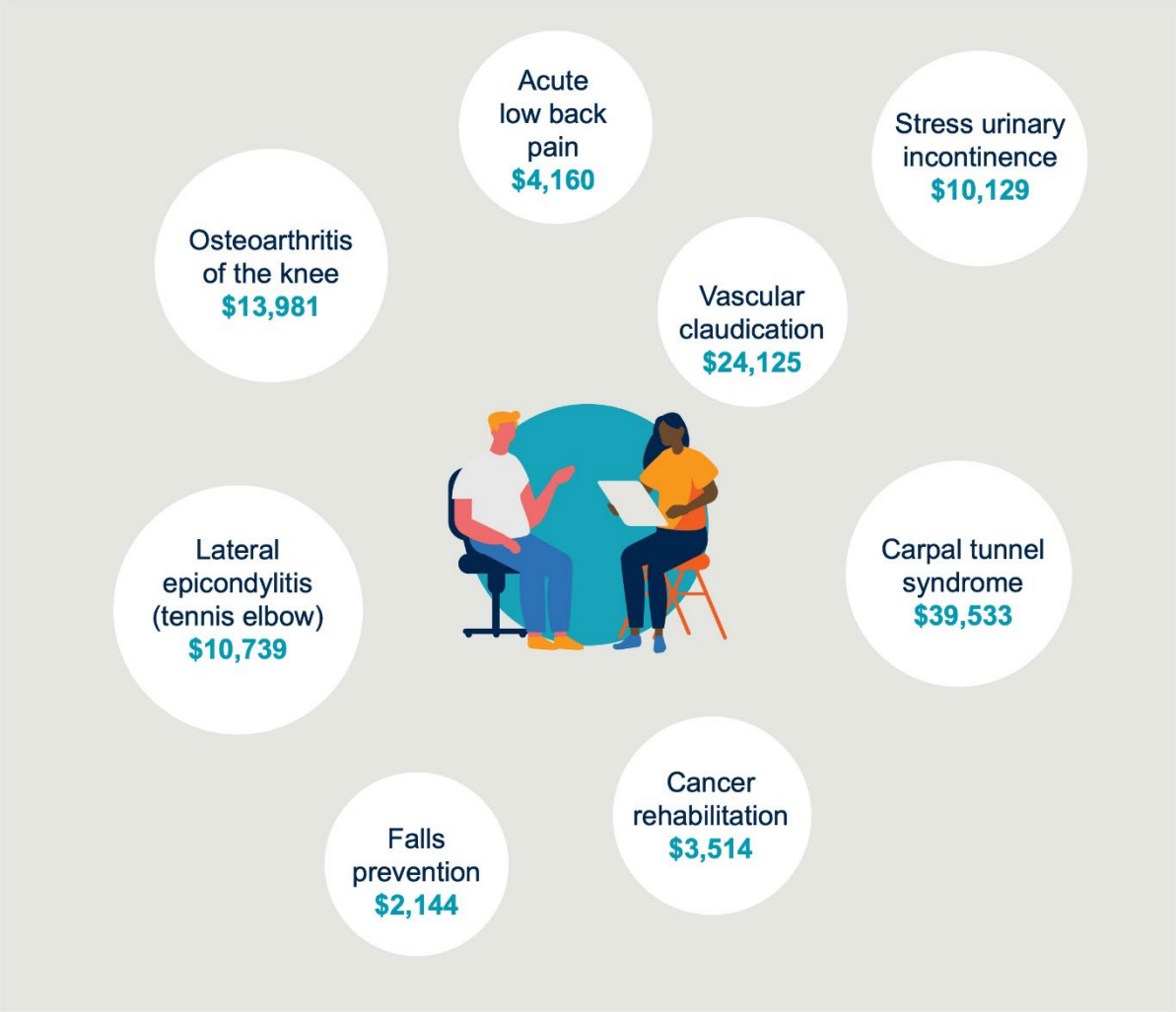
Evidence of Physical Therapy's Value Should Inform Health Care Policy to Advance Better Outcomes and Cost-Effective Care

The evidence presented in "The Economic Value of Physical Therapy in the United States" should support efforts of payers, governmental entities, and employers seeking to improve health outcomes, increase patient access and choice, and promote cost-effective care. APTA recommends that policymakers use this report to inform legislative and regulatory efforts aimed at health care delivery and payment under Medicare, Medicaid, and commercial payers.

- **Expand patient access to physical therapy for Medicare and Medicaid beneficiaries.** Policymakers should expand the definition of primary care to recognize physical therapists as entry-point providers, which will improve access and enable cost-effective care and improved outcomes. One example outlined in the report demonstrates that managing knee osteoarthritis with physical therapist services delivers a net cost benefit of approximately $14,000 per episode of care compared with the common alternative treatment of intra-articular glucocorticoid injections.
- **Provide coverage of prevention and wellness services provided by physical therapists and physical therapist assistants under federal programs.** Physical therapists routinely assess and manage risk and engage in chronic disease management to mitigate functional decline. Expanding health benefits under federal programs such as Medicare to include coverage for preventive and wellness services provided by physical therapists can help to reduce downstream costs. The report demonstrates that physical therapist services for falls prevention delivers a net cost benefit of approximately $2,100 per episode of care with respect to avoided hospital admissions and emergency department consultations.
- **Develop alternative payment models that promote physical therapists as an entry point to care.** Physical therapists are well-positioned to treat primary and secondary health care conditions. Evidence shows that physical therapist services can be more cost effective than invasive procedures such as surgery and injections. Cost or payment metrics should be used to identify the most appropriate entry point provider(s), enabling access to less invasive and less costly treatments. The report demonstrates that physical therapist services for patients with carpal tunnel syndrome deliver a net cost benefit of approximately $39,500 per episode of care compared with the alternative treatment of surgery.
- **Increase beneficiary access to physical therapist services delivered via digital health technologies.** As digital health technologies, including telehealth, expand into the health sector, physical therapists' and physical therapist assistants' access to these delivery tools should be considered in decisions regarding payment, coverage, broadband, and technology infrastructure policies. The report demonstrates that physical therapy-based cancer telerehabilitation programs deliver a net cost benefit of approximately $4,000 per episode of care.
- **Expand the physical therapy workforce in rural and underserved areas.** Rural and underserved areas often lack adequate access to health care providers. Incentivizing recruitment of physical therapists under federal workforce programs in rural and underserved areas can provide access to cost-effective treatment and reduce health disparities. Examples include adding physical therapists to the National Health Service Corps Loan Repayment Program and expanding the role of physical therapists in community health centers.

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.



Getting the Word Out: APTA's Awareness Campaign for the Report

Along with the release of "The Economic Value of Physical Therapy in the United States," APTA's awareness campaign, running over several months, will reach multiple audiences on different platforms to highlight aspects of the report demonstrating the cost-effectiveness of physical therapy for the selected health conditions. The campaign includes infographics, a foundational paper, social media posts, and more.

You can learn more about our campaign and "The Economic Value of Physical Therapy in the United States" on our ChoosePT.com or ValueofPT.com websites.

You can also get in touch with us via email or phone:

Aaron Bishop
Vice President, Public Affairs
aaronbishop@apta.org

Justin Elliott
Vice President, Government Affairs
justinelliott@apta.org

APTA Government Affairs
advocacy@apta.org
800-999-2782

LHorn Testimony Support _SB699.pdf
Uploaded by: Linda Horn
Position: FAV

Good afternoon Madame Chair and Committee Members,

Thank you for this opportunity to speak in support of SB 699. I am Dr. Linda Horn, and I have been a physical therapist for over 40 years. I am the Director for Government Relations for the American Physical Therapy Association Maryland. While I am a full-time faculty member at the University of Maryland Baltimore in the Doctor of Physical Therapy program, I also continue to treat adults who are at high risk of falling or have had a fall.

We are in the midst of the "silver tsunami" where 1 out of 6 adults in the United States are 65 and over according to the 2020 Census. According to the Centers for Disease Control, 1 in 4 older adults report falling in the last year (and this may be low as many are afraid to report this to their physician and/or family) and 112 adults die every day as a result of a fall. Research studies have shown that many falls can be prevented, and the key is to keep moving. Many older adults need physical therapy to help them safely exercise. Physical therapists can determine which muscles are weak, assess balance, decide the best exercises to do, and the need for an assistive device. It is better to evaluate and treat people BEFORE they fall, maybe in their 50's and early 60's or when they have chronic conditions.

However, there are barriers to patients being able to attend physical therapy. Most of my career has been spent treating individuals in Southwest Baltimore and they have shared with me that they are on a limited income and can't afford to come to physical therapy more than 2-3 times – not a week, but total. And most of my patients need more physical therapy to reduce fall risk. In 2023, the American Physical Therapy Association released "The Economic Value of Physical Therapy in the United States" and the average net cost savings for fall prevention is $2,144. If co-pays were lower, more patients may be able to access the amount of physical therapy they need. We chose the words 'annual physical or wellness visit' because there was opposition to the wording 'primary care' visit previously. While physical therapy is considered a specialist by insurers, we should be in a separate category outside of the physician category as we are not physicians. Physical therapy needs to be in a separate category and have a lower copay to improve access. We welcome the opportunity to discuss the actual copayment wording with the insurers. I respectfully ask that the committee gives a favorable report to SB 699.

References:

https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html

https://www.cdc.gov/steadi/patient-resources/index.html

The Economic Value of Physical Therapy in the United States, American Physical Therapy Association, 2023

Reoli Testimony SB699.pdf
Uploaded by: Rachel Reoli
Position: FAV

Madame Chair and Committee Members,

Thank you for the opportunity to speak in support of Senate Bill 699. My name is Rachel Reoli. I'm a physical therapist, I hold a PhD in Rehabilitation Science, and I'm a board-certified specialist in neurologic physical therapy. I also serve as Vice President of the American Physical Therapy Association of Maryland and am a full-time faculty member at the University of Maryland School of Medicine.

As you just heard from Dr. Horn, our population is aging—and with that comes a growing number of falls. From a neurologic perspective, falls are not minor events. Individuals who fall are at much higher risk for serious secondary injuries, including spinal cord injuries and traumatic brain injuries. These injuries can be life-altering for patients and incredibly costly for our healthcare system.

These are not short-term problems. Often, these injuries require surgery just to achieve medical stability, followed by months—or longer—of intensive rehabilitation. During that time, patients and their caregivers are frequently pulled away from work and daily responsibilities, adding to the financial and emotional strain. The costs add up quickly—not just for families, but for the system as a whole.

And the hard truth is this: many of these injuries are preventable.

Before I became a professor, I worked as a physical therapist for more than a decade. While working in an inpatient rehabilitation hospital, I treated a patient over 90 years old who had sustained a cervical spinal cord injury from a fall. I remember this patient expressing deep regret that they had not followed through with outpatient physical therapy to address balance issues earlier. While they did not explicitly say cost was the barrier, I think we can all think of older adults in our lives for whom even modest copays make preventive care out of reach.

Senate Bill 699 directly addresses that barrier. It shifts our system toward prevention rather than crisis care. It helps people access physical therapy *before* a fall occurs, *before* a life-changing injury happens, and *before* we incur far greater costs—both human and financial.

Maryland would not be alone in taking this step. To date, 13 states have passed similar legislation to limit the cost of copays, recognizing that prevention is both compassionate and fiscally responsible.

I urge you to view Senate Bill 699 not just as a healthcare bill, but as a smart investment in the safety and independence of Marylanders. By supporting this bill, you have the opportunity to prevent avoidable injuries, reduce long-term healthcare costs, and improve quality of life for countless individuals and families.

Thank you for your time, and I respectfully ask for a favorable report on Senate Bill 699.

Testimony in support of SB0699 - Health Insurance

Uploaded by: Richard KAP Kaplowitz

Position: FAV

SB0699_RichardKaplowitz_FAV
03/04/2026
Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON SB#0699 POSITION: FAVORABLE

Health Insurance - Physical Therapy - Copayments, Coinsurance, and Deductibles

TO: Chair Beidle, Vice Chair Hayes, and members of the Finance Committee
FROM: Richard Keith Kaplowitz

My name is Richard Keith Kaplowitz. I am a resident of District 3, Frederick County. I am submitting this testimony in support of SB#/0699, **Health Insurance - Physical Therapy - Copayments, Coinsurance, and Deductibles**

This bill is personal to me and to many seniors who need physical therapy but refrain from undergoing it due to costs of the therapy. The American Physical Therapy Association notes [1]

> Too often, insurance requires copays that effectively reduce access.
>
> Patients typically see a physical therapist multiple times during an episode of care, but excessive copays can make that difficult, maybe even impossible for some. Under certain health plans, copayments for physical therapy services, some exceeding $60 per visit, also can exceed the reimbursement paid by the plan to the provider of care. High copayments for physical therapy are one reason that some consumers opt to reduce their frequency of treatment or forgo medically necessary care.

The Pacific Legal Foundation warns of the consequences of not covering physical therapy under Medicare and the other barriers to care that exist. [2]

> By 2030, every baby boomer will be over 65, meaning millions will need help recovering from surgery, regaining mobility after illness or stroke, or staying active enough to avoid decline. As more people enter Medicare, they'll become locked out of options.

Maryland can and should remedy this critical situation by governing provider conduct through passing this bill. It will 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.

We must tackle this problem in an effective and responsible manner.

I respectfully urge this committee to return a favorable report on SB#/0699.

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[1] https://www.apta.org/advocacy/issues/fair-physical-therapy-copays#:~:text=Too%20often%2C%20insurance%20requires%20copays,to%20see%20you%20at%20all.
[2] https://pacificlegal.org/medicare-should-not-stop-seniors-from-accessing-physical-therapy/

2025 LENTZ PT Copays.pdf
Uploaded by: Roy Film
Position: FAV

PTJ: Physical Therapy & Rehabilitation Journal | *Physical Therapy*, 2025;105:pzaf129
https://doi.org/10.1093/ptj/pzaf129
Advance access publication date October 28, 2025
Original Research

Episode of Care Characteristics Following Implementation of a No Copay Physical Therapy Program for Musculoskeletal Conditions

Trevor A. Lentz, PT, PhD, MPH[1,2,3,4,*]; Adam Lutz, DPT, PhD[5,6]; Uchechukwu Ikeaba, MS[7]; Brooke Alhanti, PhD[7]; Steven Z. George, PT, PhD[1,2,4]; Chad Cook, PT, PhD[1,2,4]; Charles Thigpen, PT, PhD[5]

[1]Department of Orthopaedic Surgery, Duke University, Durham, NC 27710, United States
[2]Duke Clinical Research Institute, Duke University, Durham, NC 27710, United States
[3]Duke-Margolis Institute for Health Policy, Duke University, Durham, NC 27710, United States
[4]Department of Population Health Sciences, Duke University, Durham, NC 27710, United States
[5]ATI Physical Therapy, Greenville, SC 29615, United States
[6]Institute for Musculoskeletal Advancement (iMSKA), Greenville, SC 29615, United States
[7]Department of Biostatistics and Bioinformatics, Duke University, Durham, NC 27710, United States

*Corresponding author: Trevor A. Lentz, PT, PhD, MPH, Department of Orthopaedic Surgery and Duke Clinical Research Institute, Duke University, 300 W. Morgan Street, Durham, NC 27701, United States (trevor.lentz@duke.edu)

ABSTRACT

Importance: New care models promoting early access to physical therapy by reducing or eliminating copays are emerging. Few studies have compared health care use in these programs to other care pathways across musculoskeletal conditions.
Objective: The objective of this study was to describe episode-level musculoskeletal health care use across different care pathway options, including a no-copay physical therapy program.
Design: This study was a descriptive retrospective analysis of claims data.
Setting and Participants: This study included health care beneficiaries of a self-insured employer with ~52,000 covered lives.
Interventions or Exposures: The study included musculoskeletal care episodes from October 2019 to September 2020 categorized as no copay physical therapy, traditional physical therapy, or other management.
Main Outcomes: Rates of surgery/injection, imaging, inpatient services, physician services, emergency services, physical therapy, and other services by episode type, overall and stratified by body region: upper extremity, lower extremity, and spine.
Results: Of 9696 total episodes, 886 (9.1%) were no copay physical therapy, 1261 (13%) were traditional physical therapy, and 7549 (77.9%) were other management. No copay physical therapy episodes had lower imaging rates (38%) compared to traditional physical therapy (47%) and other management (45%) episodes. Inpatient services were similar for no copay (16%) and traditional (12%) physical therapy, both lower than other management episodes (23%). Physician services were higher in other management (100%) and traditional physical therapy (81%) episodes compared to no copay physical therapy episodes (43%). Surgery/injection rates were similar for no copay (11%) and traditional (8%) physical therapy, both lower than other management episodes (27%). Differences by pathway were more pronounced for extremity conditions than for spine conditions.
Conclusions: Rates of no copay program use were modest with those who used the program having lower rates of advanced imaging, injection, and surgery.
Relevance: Findings may be most relevant for employers, health systems, and payors planning resource allocation and benefit design for similar programs.

Key words: Copay; Episodes; Health Plan Implementation; Musculoskeletal Pain; Pain; Pain Management.

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INTRODUCTION

Musculoskeletal conditions account for the highest amount of annual health care spending in the United States,[1] and are the second most common cause of years lived with disability in the world.[2] Clinical practice guidelines for many musculoskeletal conditions recommend non-pharmacologic management as first line care.[3–5] Early management decisions can significantly influence the volume and type of future health care use,[6–9] with studies showing limited value of early pharmacologic treatment and advanced imaging for most conditions.[10–16] As a result, health care systems and payers have taken a strong interest in high value care models that promote early and initial use of non-pharmacologic treatments, including those commonly provided by physical therapists.[17–21] Exposure to these treatments early in an episode of care has demonstrated potential to shift downstream care away from opioids[22] and procedures like advanced imaging, injection, and surgery,[8,22–28] often resulting in similar or slightly higher costs but better outcomes.[23,29,30]

Studies consistently support the benefits of early non-pharmacologic treatment but a major challenge for many health systems and payors is understanding how to encourage its use. One method is through the use of value-based insurance designs that reduce or eliminate visit copays for non-pharmacologic services like physical therapy since financial barriers are a common reason why patients do not use these services.[31–34] Programs that lower cost-sharing are gaining popularity but few studies have assessed real-world outcomes when patients are offered a no copay physical therapy option. Existing studies on these or similar programs focus exclusively on spine conditions rather than the broader range of musculoskeletal conditions commonly managed by physical therapists.[32,34–38] Expanding analyses to include non-spine musculoskeletal conditions is essential for refining and scaling these models.

Despite the expected impact of removing out-of-pocket costs for consumers, reducing or eliminating cost sharing doesn't always lead to changes in health care use or a shift to more guideline-concordant use of services.[39–42] Accordingly, the aim of this descriptive study was to report on rates of health care use across different musculoskeletal care pathway options available to beneficiaries of a self-insured employer, including a program that eliminates physical therapy copays to encourage its use as an early or initial treatment. We expected to observe that rates of health care will differ across care pathways, with the lowest rates of imaging, injection, and surgery among those in the no copay program. We are particularly interested in health care use metrics as an outcome because inconsistent reimbursement rates and carve-outs in programs like these make cost analyses less generalizable.

METHODS

Overview of No Copay Physical Therapy Program

Beginning in fall of 2018, ATI Physical Therapy, one of the largest providers of physical therapist services in the United States, partnered with a self-insured employer to offer physical therapy as the preferred, but not exclusive, provider for their ~52,000 beneficiaries. The program aims to encourage adult beneficiaries to choose physical therapy as an early or first line of treatment for musculoskeletal conditions by removing copay/coinsurance requirements for physical therapist services. The benefit exists fully outside of other employed-sponsored health benefits (ie, a benefit carve-out) meaning that use of physical therapy has no impact on the health plan deductible and is delivered at no cost to the beneficiary. The third-party administrator is not involved with the ATI-employer claims. The employer has a fully self-funded benefits platform, paying claims through a direct bill contract with ATI. ATI submits claims directly to the employer, who then self-adjudicates all ATI claims.

Although the program was facilitated by state-level direct access privileges and encouraged physical therapy as an initial treatment, it should not be considered a "physical therapy first" or exclusively direct access program, as the benefit is not contingent upon seeing a physical therapist first or directly without a physician referral. To date, the program has been provided at 252 ATI clinics, with beneficiaries primarily located in Illinois (74%) and Indiana (24%). Beneficiaries do not have to choose this benefit and instead could choose other management options like physical therapist treatment outside of ATI, chiropractic care, and/or care led by a physician that might include treatments like medications, injections, or surgery. Participation in the no copay program would not disqualify them from using any other type of care, nor would use of other treatments disqualify them from using the no copay program at any time.

Beneficiaries are made aware of the program through promotional materials jointly developed between ATI and the employer. This includes a vendor card with information about the program provided to all beneficiaries with their insurance cards. Information on the program is also provided during regular employer-sponsored benefit fairs, in member newsletters, as part of the new member benefit packet, through onsite primary care clinics, and on the employer benefits website under "free services."

Data Sources

Analysis data were extracted from the employer claims dataset and ATI databases. The employer claims dataset includes typical commercial claims data such as claim/beneficiary IDs; dates (Start/Stop/Paid); provider name and state; diagnoses and billed procedure codes; and billed amount/paid amount. Total adjudicated claims were acquired for all beneficiaries that had received care. Beneficiary IDs in the claims dataset were linked to unique patient IDs in the ATI administrative database to extract geographic (patient/provider address) and visit & billing information. This linkage allowed for the identification of all beneficiaries participating in the program. The Duke University Institutional Review Board approved this study.

Analytic Sample

To create the full analytic dataset, we extracted all health care claims for all beneficiaries between October 1, 2018, and September 30, 2020, which was the range of dates from program initiation to the latest date that data were available at the beginning of this analysis. Criteria used for developing the final analytic sample are depicted in Figure 1 and the development process is described below.

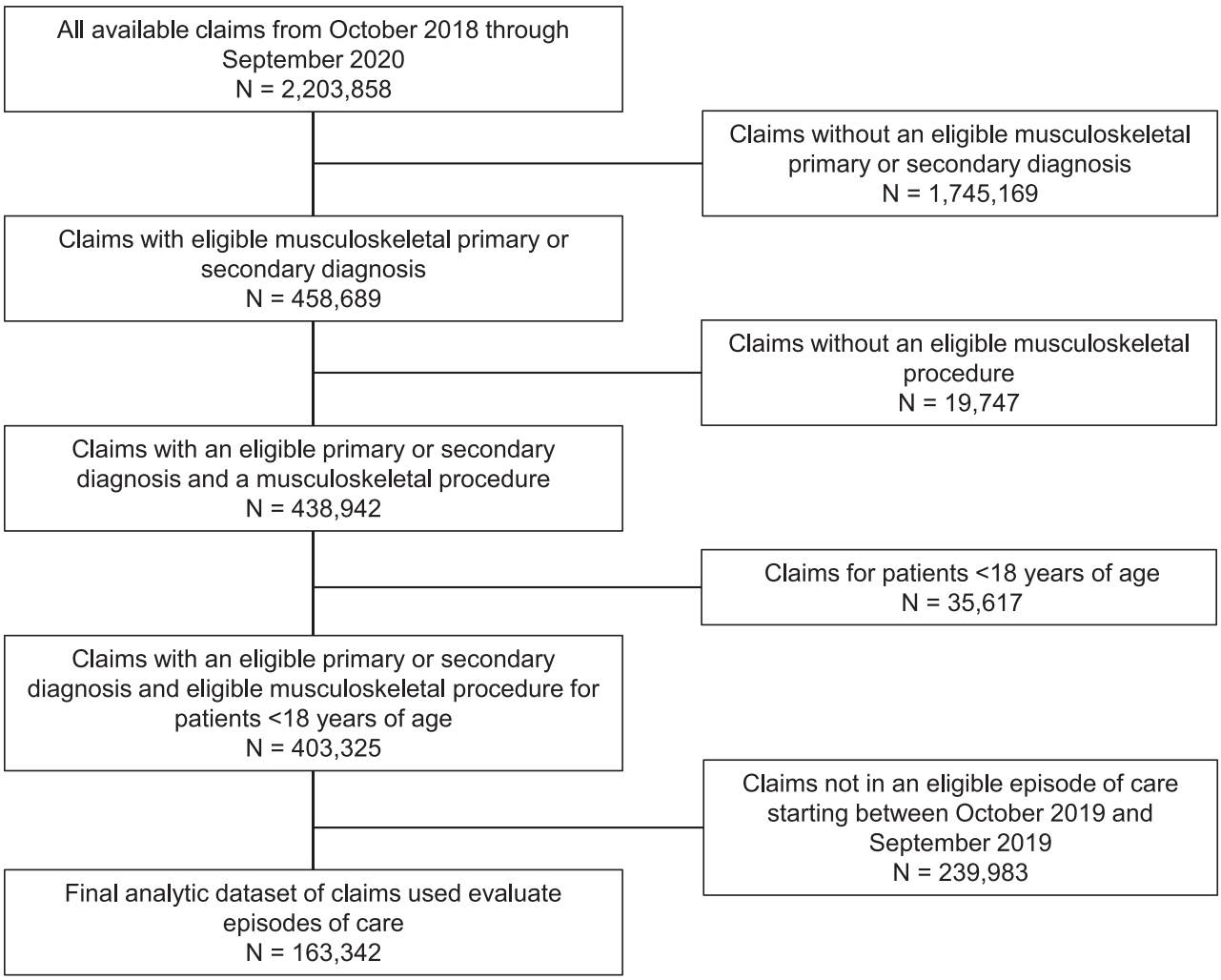

Figure 1. Inclusion and Exclusion Criteria.

Establishing Eligible Diagnoses and Procedures

Episodes are comprised of one or more claims, and claims are comprised of one or more procedures (ie, claim line item). We first established eligible diagnoses for inclusion. All procedures have one or more associated ICD-10 diagnosis code. Our goal was to measure musculoskeletal-related health care use following implementation of a program aimed at improving early access to physical therapists. As a result, we limited eligible musculoskeletal diagnoses to those that would be generally appropriate for early and initial treatment by physical therapists. For example, we excluded musculoskeletal diagnoses such as fracture, laceration, amputation, spinal cord injury, congenital abnormalities and others that would require treatment by physicians or other health care providers. We established the list of diagnoses through an iterative consensus-building process. The process started with an initial list of all ICD-10 codes present within any diagnosis field in the claims dataset. The lead author (T.L.) reviewed this list and classified each diagnosis as included or excluded based on expertise, experience, and review of diagnostic code and/or musculoskeletal literature, as needed. The preliminary classifications were then reviewed by 4 other musculoskeletal physical therapist experts (A.L., C.C., S.G., C.T.) with experience in health services research and clinical care. Disagreements were discussed and final decisions made by consensus.

Next, we selected all procedures that included an eligible ICD-10 code (Suppl. Table 1) as the primary or secondary diagnosis. We then reviewed the pool of procedures linked to eligible diagnosis codes and excluded those that were clearly not related to musculoskeletal treatment. Ineligible procedures were determined by the same iterative consensus-building process as previously outlined for selection of diagnosis codes. The presence of musculoskeletal diagnoses on non-musculoskeletal procedures (eg, prostate cancer screening, vaccinations, mammography) often occurs in claims data when patients are seen at the same visit for multiple diagnoses, or when using pre-populated problem lists. This method ensured we only analyzed procedures that are likely to be for musculoskeletal management. The eligible procedures were then grouped into 1 of the following musculoskeletal utilization groupings: surgery/injection, imaging, inpatient, physician services, emergency services, physical therapy, and other services. Other services would be those not fitting the aforementioned groupings and commonly included services like acupuncture, chiropractic care, and durable medical equipment. It also included codes for pain-relieving modalities like transcutaneous electrical nerve stimulation

used and billed for by a variety of different health care providers.

Grouping Diagnosis Codes

Because the same musculoskeletal condition could be documented with slightly different ICD-10 codes across different settings, we developed a diagnosis grouping schema for all eligible ICD-10 codes. Diagnosis code groups included: wrist/hand, elbow, shoulder, spine, hip, knee, foot/ankle, and other (eg, generalized osteoarthritis, polyarthritis). Each procedure was required to have a primary diagnosis code or a secondary diagnosis code (or both) in the list of eligible musculoskeletal ICD-10 codes and therefore could have up to 2 diagnosis group allocations. We include primary and secondary diagnoses because although secondary diagnosis codes are less commonly used in outpatient settings,[43] we were trying to attribute procedures to conditions across a variety of different services (eg, inpatient, emergency department, outpatient) that use slightly different coding conventions. For this reason, we took a more inclusive approach to ensure we include all musculoskeletal services delivered for the index condition.[44–46]

Defining Episodes of Care

All analyses were at the episode level. We took a sequence of steps (described below) to define episodes and identify which were eligible for inclusion in the final analyses.

Setting Start and End Date

Using the pool of eligible procedures, we next assembled musculoskeletal episodes of care. The first step in this process was to identify evaluation and management (E&M) procedures to establish an index, or start date, of the episode. We limited episode initiation to outpatient physician/chiropractor and physical therapist visits (ie, no episodes beginning with ED or inpatient visit). Eligible index procedures were identified by physician evaluation and management (E&M) CPT codes (99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215) or physical therapist evaluation CPT codes (97161, 97162, 97163, 97001), hereafter all referred to as "evaluation procedures."

We then examined the 90 days prior to each evaluation procedure date to determine if other evaluation procedures were present with a primary or secondary ICD-10 code in the same diagnosis group. If no other procedures were present, we would use that evaluation to set the episode index date. Otherwise, we would find the earliest evaluation procedure with the same diagnosis group to set as the episode index date. The diagnosis code group(s) associated with the evaluation procedure on the index date was considered as the "index condition." The episode would then run until that patient had no procedures or treatments for the index condition for 90 days or until the episode length reached 365 days, whichever was sooner.[47,48] For episodes not censored at 1 year, the episode end date was assigned as the last procedure date before the 90-day window with no procedures for the index condition.

Identifying Procedures That Belong to an Episode

All procedures on or after the index date, and on or before the end date, were considered part of the episode if their primary or secondary diagnosis group matched the primary or secondary diagnosis group of the evaluation procedure. Episodes for different conditions could run concurrently for the same person if initiated by different evaluation procedures. Procedures where the primary diagnosis group matched the index condition of 1 episode and the secondary diagnosis group matched the index condition of another episode running concurrently were attributed based on their primary diagnosis. The algorithm for defining episodes of care is depicted in Figure 2.

Classifying Episodes

Episodes were classified into mutually exclusive categories that reflect distinct pathways of musculoskeletal care. We first determined whether the episode included a physical therapist evaluation. Episodes that did not include a physical therapist evaluation were classified as "*other management*" (Figure 3, decision node A). Of the episodes that included physical therapy, we determined whether physical therapy was a primary management strategy. We operationally defined physical therapy as a "primary management strategy" if it was received prior to other services like advanced imaging, injection, or surgery, if those occurred in the episode, or if it was the only care received (Figure 3, decision node B). We were interested in distinguishing these episode types (regardless of where physical therapy was received) because the care sequence would be considered guideline concordant. If physical therapy was received only after receiving surgery, injection, or advanced imaging, these episodes would also be classified as other management. In summary, other management episodes either excluded physical therapy altogether or included it (at ATI or elsewhere) only after injection, surgery, or advanced imaging. The intention of the no copay benefit is that beneficiaries would access physical therapy relatively early in their care episode. Our primary interest in this analysis was to describe episode level care for those that used the benefit as intended. Therefore, with the remaining episodes, we identified those that included physical therapy delivered through the no copay program and classified those that initiated physical therapy within 90 days of the episode index date as no copay physical therapy (Figure 3, decision node C). We chose 90 days as this is a reasonable timeframe in which we would expect most patients to seek physical therapy for their condition and take advantage of the no copay benefit. Episodes that included physical therapy in the no copay program but initiated after 90 days from the episode index date were classified as traditional physical therapy. Traditional physical therapy also included episodes that used physical therapy outside of ATI as a primary management strategy, regardless of when it started in the episode. A summary of these classifications and examples episodes are provided in Suppl. Figure 1.

Statistical Analysis

Health care use was summarized by episode classification and for all episodes regardless of classification. We report counts of unique patients, total number of procedures, and total number of episodes as well as mean (SD) and median (25th, 75th) number of procedures per episode. Number of visits per episode was determined by the number of distinct dates of service at the procedure level. We report results by overall sample and stratified by primary body region: upper extremity, lower extremity, and spine. As described, the program did not require beneficiaries to access physical therapy first (ie, before other services) or directly without a physician referral. Direct access and "physical therapy first"

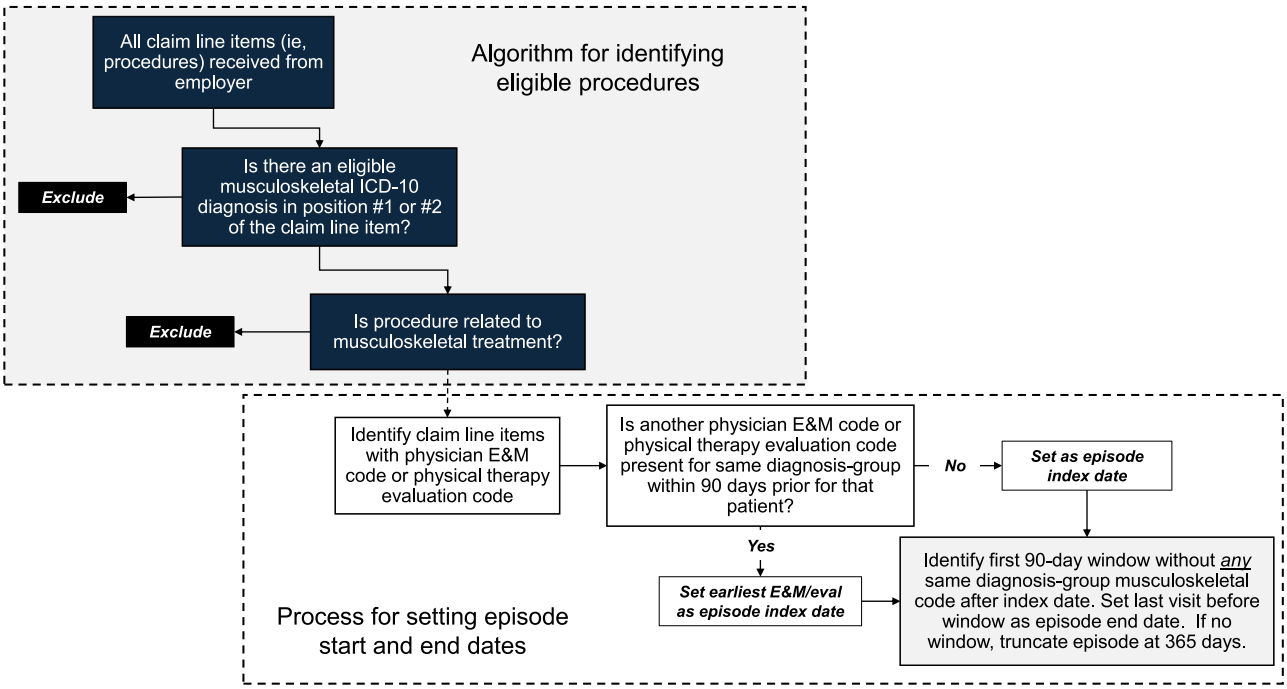

Figure 2. Algorithm for Eligible Procedures and Process for Setting Episode Start and End Date. Abbreviation: E&M = evaluation and management.

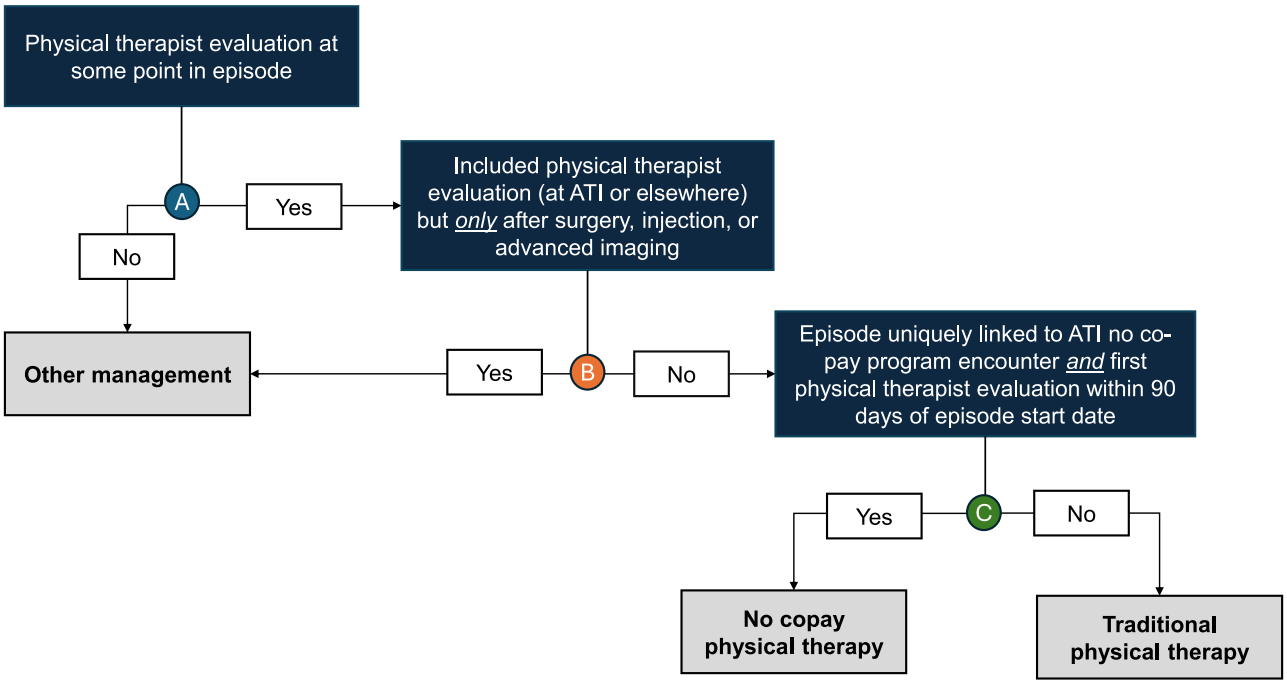

Figure 3. Algorithm for Assigning Musculoskeletal Episodes to a Care Pathway. Episodes that did not include a physical therapist evaluation were classified as "other management" (decision node A). Of the episodes that included physical therapy, we determined whether physical therapy was a primary management strategy. We operationally defined physical therapy as a "primary management strategy" if it was received prior to other services like advanced imaging, injection, or surgery, if those occurred in the episode, or if it was the only care received (decision node B). For the remaining episodes, we identified those that included physical therapy delivered through the no copay program and classified those that initiated physical therapy within 90 days of the episode index date as no copay physical therapy (Figure 2, decision node C). Episodes that included physical therapy outside of ATI or in the no copay program but initiated after 90 days from the episode index date were classified as traditional physical therapy.

are distinct characteristics of physical therapy use that can confer their own potential benefits beyond accessing physical therapy "early" in the care episode.[18] While we could not determine if beneficiaries accessed physical therapy directly without physician referral, we could examine episode characteristics among beneficiaries that accessed the program at the beginning of their episode versus later. Therefore, in an exploratory analysis, we separately described health care use among no copay physical therapy episodes where beneficiaries (1) accessed physical therapy on or within 1 day of the index date and (2) accessed physical therapy later. The intent of this analysis was to explore differences based on timing of physical

therapy initiation among those who used the program as intended. All analyses were performed using SAS (Version 9.4, SAS Institute Inc., Cary, NC, United States).

Role of the Funding Source

The funding source, ATI Holdings, LLC, provided all data and input on the research question and study design. ATI reviewed the manuscript only to ensure accuracy of the program description and Duke investigators had full scientific freedom to publish results.

RESULTS

Health Care Use by Episode Classification—Overall Sample

The analysis included unique 7349 patients undergoing 9696 episodes of care. Distribution of patients (number of episodes, % of total episodes) by classification were: 849 (886, 9.1%) in no copay physical therapy, 1208 (1261, 13.0%) in traditional physical therapy, and 5888 (7549, 77.9%) in other management (Table 1). Among the no copay physical therapy episodes, 636 (71.8%) included physical therapy on the first (index) day of the episode, 207 (23.4%) had physical therapy starting between 1 and 30 days of the episode index date, 26 (2.9%) had physical therapy starting between 31 and 60 days of the episode index date, and the remaining 17 (1.9%) had physical therapy starting between 61 and 90 days of the episode index date. There were 48 ATI-linked episodes where physical therapy was initiated after 90 days and these were included in the traditional physical therapy cohort. Across the entire sample, ~8.1% of episodes for different conditions ran concurrently. The median number (interquartile range) of days per episode were 43 (28–78) for no copay physical therapy, 47 (20–104) for traditional physical therapy, and 1 (1–51) for other management. The median number (interquartile range) of visits per episode was 12 (8–16) for no copay physical therapy, 8 (4–16) for traditional physical therapy, and 1 (1–4) for other management.

No copay physical therapy episodes had lower rates of imaging and physician services compared to other pathways (Table 1 and Suppl. Figure 2). No copay physical therapy episodes and traditional physical therapy had similar rates of surgery/injection and inpatient visits that were both lower than observed rates in other management episodes. Use of physical therapy and other services was highest in both physical therapy groups, while emergency service use was similar across all pathways.

In a post-hoc exploratory analysis of no copay physical therapy episodes, we assessed health care use by whether physical therapy was initiated on the first or second day (n = 654 episodes) versus later in the episode (n = 226) (Suppl. Table 2). The most notable difference in this exploratory analysis was for imaging, where 26.3% of early physical therapy episodes included imaging procedures compared to 72.0% of later physical therapy episodes. Approximately 23% of early physical therapy episodes included physician services compared to 100% of episodes where physical therapy was initiated later.

Health Care Use by Episode Classification—Stratification by Body Region

Upper Extremity

Of the 1688 upper extremity episodes during the observation period, 1388 (82%) were other management, 171 (10%) were no copay physical therapy, and 129 (8%) were traditional physical therapy (Table 2). Rates of imaging (52%), inpatient care (25%), physician services (100%), and surgery/injection (40%) were higher in other management episodes compared to episodes in either physical therapy care pathway, while both physical therapy pathways had higher rates of physical therapy and other services. Comparing the 2 physical therapy pathways, rates of imaging (46%) and surgery/injection (18%) were higher for no copay physical therapy, while use of physician services was lower (42%). Rates of emergency service use were similar across pathways, around 2% to 5%. Differences in proportion of episode-level health care use compared to no copay physical therapy stratified by body region are provided in Table 3.

Lower Extremity

Of the 3221 lower extremity episodes during the observation period, 2462 (83%) were other management, 262 (8%) were no copay physical therapy, and 197 (6%) were traditional physical therapy (Table 2). Rates of imaging (56%), inpatient care (24%), physician services (100%), and surgery/injection (33%) were higher in other management episodes than in both physical therapy pathways, while both physical therapy pathways had higher rates of physical therapy and other services use (96%–100%). Comparing the 2 physical therapy pathways, rates of imaging (51%), surgery/injection (17%), and physician services (67%) were higher in traditional physical therapy episodes. Rates of emergency service use were higher in traditional physical therapy episodes (11%) compared to both other pathways (4%–6%).

Spine

Of the 4027 spine episodes during the observation period, 2839 (70%) were other management, 812 (20%) were traditional physical therapy, and 376 (9%) were no copay physical therapy (Table 2). Rates of inpatient services (11%) and surgery/injection (5%) were lowest among traditional physical therapy episodes, while traditional physical therapy had higher rates of imaging (49%) compared to no copay physical therapy (32%) and other management (33%). Episodes in both physical therapy pathways had higher rates of physical therapy (100%) and other services (98%–100%) and lower rates of physician services (no copay: 41%; traditional physical therapy: 90%) than other management episodes. Rates of emergency service use were similar across pathways (4%–5%).

DISCUSSION

This study examined episode-level health care use following the launch of a no copay program aimed at promoting early treatment by physical therapists. During the observation period, 9% of episodes were classified as no copay physical therapy. When including episodes in the traditional physical therapy group, ~22% of all episodes used physical therapy as a primary management approach. Historically, use of physical therapy for musculoskeletal conditions has been low, ranging from 3% to 24%,[33,49–52] with even lower rates for early intervention.[23] Our findings are consistent with these rates. When assessing program uptake, it is worth highlighting that 41% of the beneficiaries selecting physical therapy as a primary management strategy did so through the no copay program. The optimal rate of program use is difficult to determine, but readers should consider that this was a newly implemented

Table 1. Distribution of Musculoskeletal (MSK) Services by Care Pathway

Health Care Service	Overall	No Copay Physical Therapy	Traditional Physical Therapy	Other Management
All MSK services				
Number of unique patients	7349	849	1208	5888
Episode procedures				
Total number procedures	163,342	39,482	42,596	81,264
Mean number of procedures per episode (SD)	17 (29)	45 (34)	34 (35)	11 (23)
Median number of procedures per episode (25th, 75th)	5 (2–19)	38 (24–55)	22 (10–46)	3 (1–8)
Episodes of care				
Total number of episodes of care	9696	886	1261	7549
Mean number of days per episode (SD)		68 (71)	81 (91)	42 (76)
Median number of days per episode (25th, 75th)		43 (28–78)	47 (20–104)	1 (1–51)
Mean number of visits per episode (SD)		14 (10)	12 (11)	5 (8)
Median number of visits per episode (25th, 75th)		12 (8–16)	8 (4–16)	1 (1–4)
MSK service groups				
Emergency services				
Number of unique patients	461	34	64	364
Episode procedures				
Total number procedures	992	66	124	802
Mean number of procedures per episode (SD)	0 (1)	0 (1)	0 (1)	0 (1)
Median number of procedures per episode (25th, 75th)	0 (0–0)	0 (0–0)	0 (0–0)	0 (0–0)
Episodes of care				
Total number of episodes of care	486 (5.0%)	35 (4.0%)	64 (5.1%)	387 (5.1%)
Imaging				
Number of unique patients	3758	330	585	3012
Episode procedures				
Total number procedures	9707	1055	1664	6988
Mean number of procedures per episode (SD)	1 (2)	1 (3)	1 (3)	1 (2)
Median number of procedures per episode (25th, 75th)	0 (0–1)	0 (0–1)	0 (0–2)	0 (0–1)
Episodes of care				
Total number of episodes of care	4342 (44.8%)	339 (38.3%)	592 (46.9%)	3411 (45.2%)
Inpatient				
Number of unique patients	1795	137	144	1563
Episode procedures				
Total number procedures	15,573	1072	850	13,651
Mean number of procedures per episode (SD)	2 (6)	1 (5)	1 (3)	2 (7)
Median number of procedures per episode (25th, 75th)	0 (0–0)	0 (0–0)	0 (0–0)	0 (0–0)
Episodes of care				
Total number of episodes of care	1991 (20.5%)	139 (15.7%)	146 (11.6%)	1706 (22.6%)
Other services				
Number of unique patients	3960	849	1178	2171
Episode procedures				
Total number procedures	66,980	21,059	20,597	25,324
Mean number of procedures per episode (SD)	7 (14)	24 (17)	16 (19)	3 (10)
Median number of procedures per episode (25th, 75th)	0 (0–7)	21 (13–29)	10 (4–22)	0 (0–1)
Episodes of care				
Total number of episodes of care	4473 (46.1%)	886 (100%)	1229 (97.5%)	2358 (31.2%)
Physical therapy				
Number of unique patients	2533	849	1208	598
Episode procedures				
Total number procedures	43,466	14,821	16,157	12,488
Mean number of procedures per episode (SD)	4 (12)	17 (15)	13 (16)	2 (8)
Median number of procedures per episode (25th, 75th)	0 (0–2)	13 (8–21)	7 (2–17)	0 (0–0)
Episodes of care				
Total number of episodes of care	2759 (28.5%)	886 (100%)	1261 (100%)	612 (8.1%)
Physician services				
Number of unique patients	6870	372	986	5888
Episode procedures				
Total number procedures	19,903	1064	2758	16,081
Mean number of procedures per episode (SD)	2 (3)	1 (2)	2 (3)	2 (3)
Median number of procedures per episode (25th, 75th)	1 (1–2)	0 (0–1)	1 (1–2)	1 (1–2)
Episodes of care				
Total number of episodes of care	8950 (92.3%)	383 (43.2%)	1018 (80.7%)	7549 (100%)
Surgery/injection				
Number of unique patients	1935	100	106	1763
Episode procedures				
Total number procedures	6721	345	446	5930
Mean number of procedures per episode (SD)	1 (2)	0 (2)	0 (2)	1 (2)
Median number of procedures per episode (25th, 75th)	0 (0–0)	0 (0–0)	0 (0–0)	0 (0–1)
Episodes of care				
Total number of episodes of care	2252 (23.2%)	101 (11.4%)	106 (8.4%)	2045 (27.1%)

Table 2. Distribution of Musculoskeletal Services for Each Care Pathway Stratified by Body Region

Health Care Service	Total			Upper Extremity			Lower Extremity			Spine		
	No Copay Physical Therapy	Traditional Physical Therapy	Other Management	No Copay Physical Therapy	Traditional Physical Therapy	Other Management	No Copay Physical Therapy	Traditional Physical Therapy	Other Management	No Copay Physical Therapy	Traditional Physical Therapy	Other Management
Sample size (n)	886	1261	7549	171	129	1388	262	197	2762	376	812	2839
Emergency services	4%	5%	5%	3%	2%	5%	4%	11%	6%	4%	4%	5%
Imaging	38%	47%	45%	46%	40%	52%	44%	51%	56%	32%	49%	33%
Inpatient	16%	12%	23%	15%	13%	25%	14%	16%	24%	18%	11%	20%
Other services	100%	97%	31%	100%	95%	22%	100%	96%	26%	100%	98%	42%
Physical therapy	100%	100%	8%	100%	100%	13%	100%	100%	9%	100%	100%	5%
Physician services	43%	81%	100%	42%	61%	100%	44%	67%	100%	44%	90%	100%
Surgery/injection	11%	8%	27%	18%	13%	40%	10%	17%	33%	10%	5%	16%

Table 3. Differences in Episode-Level Health Care Use Compared to the No Copay Program Stratified by Body Region

Health Care Service	Total		Upper extremity		Lower extremity		Spine	
	Traditional physical therapy	Other management	Traditional physical therapy	Other management	Traditional physical therapy	Other management	Traditional physical therapy	Other management
Emergency services	1%	1%	−1%	2%	7%	2%	0%	1%
Imaging	9%	7%	−6%	6%	7%	12%	17%	1%
Inpatient	−4%	7%	−2%	10%	2%	10%	−7%	2%
Other services	−3%	−69%	−5%	−78%	−4%	−74%	−2%	−58%
Physical therapy	0%	−92%	0%	−87%	0%	−91%	0%	−95%
Physician services	38%	57%	19%	58%	23%	56%	46%	56%
Surgery/injection	−3%	16%	−5%	22%	7%	23%	−5%	6%

program. Changing patient and clinician beliefs and behaviors around physical therapy can take time. As an observational study, we could not determine why some patients who sought physical therapy did not use the no-copay option. Possible reasons include a preference for a known therapist outside the program, lack of access to participating clinics (eg, too far from home), or limited awareness of the benefit despite promotional efforts. Given that the program targeted conditions well-suited for early physical therapy management, there are clear opportunities to expand its reach and impact. Strengthening direct-to-consumer marketing around the value and accessibility of physical therapy as a first-line treatment for common musculoskeletal issues could prompt more people to use this benefit.

Approximately 95% of beneficiaries in the program accessed physical therapy within 30 days of starting care, and over half did so on the episode index date. These results suggest the benefit successfully promoted early engagement with physical therapy, as intended. Our exploratory analysis showed that beneficiaries in the program who began therapy on the first or second day of the episode had even lower rates of imaging, surgery/injections, and physician services. These findings should be interpreted with caution due to the small sample, but are consistent with other studies showing similar trends.[6–9] No copay physical therapy episodes had a higher median number of physical therapist procedures (13) compared to traditional physical therapy episodes (7) suggesting that removal of this financial barrier may have encouraged greater use of physical therapy for those who selected it as a primary management approach. Total visits were also concentrated within a slightly shorter period of time, consistent with findings from a systematic review showing shorter episode length for earlier versus later initiation of physical therapy.[53] These insights are particularly relevant for employers, health systems, and payors planning resource allocation and benefit design for similar programs. Specifically, a no copay benefit may result in higher intensity physical therapy use and modestly shorter episode lengths compared to traditional models of physical therapy delivery.

This study was observational and used claims data that lacked patient- and clinic-level characteristics. Beneficiaries in this study chose their care rather than being randomly assigned, resulting in selection bias that could not be addressed with our design or available data. As a result, we cannot attribute differences in health care use solely to the absence of a copay. Prior research has clearly demonstrated that people who choose to access physical therapy early differ from those who choose other types of initial care or forgo physical therapy altogether. For example, people who prefer conservative approaches like physical therapy tend to be younger, have better mental and physical health, higher income, and better health-related quality of life.[54] Marrache et al found that patients who receive early physical therapy are more likely to be female, younger, and have fewer comorbid conditions than those who do not receive early physical therapy.[26] Fritz and colleagues reported that a history of spine surgery, comorbid hypertension, and receiving opioid prescription medication were associated with lower odds of initiating physical therapy within 14 days of a primary care visit for low back pain.[55] Similarly, Magel et al found that

patients with opioid use disorder were less likely to begin physical therapy after a primary care visit.[56] Together, these studies suggest that people who choose physical therapy as a primary or early treatment tend to be younger and healthier, characteristics that can independently drive lower use of injection, surgery, and advanced imaging. Two key implications follow. First, we cannot infer with our study design who is most likely to benefit from being offered a no copay physical therapy option. This will require further investigation. Second, policies that require all beneficiaries, regardless of care preference, to use such a program would likely produce different results than those presented here.

We report differences in use rates but leave it to the reader to determine whether the magnitude of difference is meaningful or not since meaningfulness thresholds are likely to differ by stakeholder. Compared to no copay physical therapy, other management episodes had higher rates of imaging, inpatient care, physician services, and surgery/injection, and lower rates of physical therapy and other services. These differences were especially prominent for upper and lower extremity conditions and less so for spine conditions. Our design also allows for comparisons of 2 models that include exposure to physical therapists. Traditional physical therapy had higher rates of imaging and physician services, but health care use rates varied considerably by body region. Collectively, these findings suggest the potential value of a no copay model may be dependent on the body region being treated, a finding which is novel considering most other studies on this topic have not assessed differences in health care use by body region.

One final important contribution of this work is its description of episode composition. We saw the highest number of procedures per episode for no copay physical therapy. The greater number of per-episode procedures and visits observed for no copay physical therapy could be due to a few factors. The most obvious is that physical therapy commonly involves multiple procedures (eg, exercise, manual therapy) over numerous visits in contrast to other forms of care (eg, medical management) that tend to be more episodic. Another reason could be that individuals might overconsume services when they no longer bear any out-of-pocket expenses, a so-called moral hazard problem.[57] It is also plausible that higher intensity health care users may be more inclined to access program with no out of pocket costs. Episode composition and length are highly relevant for health systems and payors interested in implementing similar models because these metrics are used to set benchmarks and design benefit plans. This program was structured as a benefit carve-out, with preferred provider negotiated rates that kept the per visit rate at a feasible level, even though the out-of-pocket portion was waived. The scalability of similar initiatives depends heavily on effective benefit design and the extent to which they generate downstream cost savings for patients and payors yet sustainable clinical margins.

Limitations

Our findings should be interpreted in the context of a few considerations. The most important consideration is that this study is descriptive and not analytic. Our intention was to describe health care use across different pathway options when a no copay option is available, but we cannot attribute our findings to the specific effects of the no copay benefit. We also did not have patient-reported outcomes related to pain, disability, and quality of life. This is important because a major value proposition of models that promote early exposure to physical therapy is that patient-reported outcomes are similar or better than if physical therapy is delayed or not received.[53] This is 1 of many studies that will be required to understand the benefits of no copay physical therapy models, and future analyses should incorporate patient-reported outcomes.

Claims data offer valuable insights into how care is delivered in real-world settings[58] but readers should consider common limitations associated with any study that uses claims in research. We had to make assumptions about how the data reflect actual care received. We took a liberal approach to include diagnoses appropriate for early and initial treatment by physical therapists. This strategy created a diverse pool of diagnoses that could theoretically be managed through any of the 3 pathways. We also selected procedures that could be considered musculoskeletal-focused. Expanding or reducing the eligible code lists or considering more or fewer diagnosis fields at the procedure level could influence our findings. Narrower diagnostic categories, more refined procedure lists, and use of more or fewer diagnosis fields (ie, considering primary diagnosis field only) could provide more precise estimates of use for specific conditions but could make findings less generalizable.

Defining episodes of care also comes with an inherent amount of error. We used flexible diagnosis code grouping by body region to build episodes, which was necessary to overcome variability in how different providers assign diagnostic codes for treatment of the same condition or injury. A drawback of this approach is that we could erroneously group treatments of dissimilar conditions within the same body region (eg, ankle sprain and ankle osteoarthritis) into the same episode. In developing the methodology for our project, we manually reviewed hundreds of episodes and anecdotally found this scenario to be very rare. Nevertheless, this methodological decision could result in some episodes that include concurrent or consecutive treatment of different conditions in the same body region.

A few additional limitations are worth noting. First, we did not have prescription data, which could be 1 reason for shorter episode lengths in the medically focused group. If a beneficiary was treated exclusively with prescription medication, it is likely their episode length would be underestimated in our analysis. Second, our study population included beneficiaries (employees and their families) of a self-ensured employer, which may limit generalizability to other populations or health systems. While using multiple providers and systems is a strength, it may also introduce variability and potential sources of error. Third, due to the nature of claims data we could not evaluate some diagnostic details that can influence health care use, like symptom acuity or severity. These should be considered in future analyses of no copay programs. Fourth, we grouped a variety of care options into the other management category. Our intent was not to compare every possible care strategy, but to contrast the no-copay program with traditional physical therapy and non-physical therapy alternatives. Readers should review how comparison groups were defined when interpreting results. Notably, chiropractic care is another form of non-pharmacologic musculoskeletal treatment that shares similar care pathway characteristics with physical therapy,[9,22] and may serve as a useful comparator in future studies.

Finally, our analysis included health care delivered during the COVID-19 pandemic. We considered modifying eligible episode start dates or excluding this period but doing so

would have resulted in too short a window to evaluate care pathways. In this and other analyses that used the same dataset, we observed reductions in health care use during COVID that impacted all services similarly. Readers should note that to be eligible for this analysis, beneficiaries had to start their care (index date) on or before September 30, 2019, so the pandemic would not have been a factor in selection of a care pathway. However, it may have affected subsequent care decisions, which should be considered a potential limitation.

CONCLUSION

No-copay physical therapy programs for musculoskeletal conditions are proposed to enhance value by promoting early use of non-pharmacologic care options and reducing exposure to advanced imaging, injection, and surgery. This study described episode of care characteristics among beneficiaries who were offered a no copay physical therapy option, with ~9% of beneficiaries selecting this option over other care options. We observed lower use of services like advanced imaging, surgery/injection and physician visits among those who chose the no copay option, however we could not control selection bias which prohibits establishment of a causal link between benefit design and health care use. We also did not have access to patient-reported outcomes, which makes future research necessary to fully assess the value of these programs.

CRediT—CONTRIBUTOR ROLES

Trevor A. Lentz (Conceptualization [lead], Funding acquisition [lead], Investigation [equal], Methodology [equal], Project administration [lead], Resources [equal], Supervision [lead], Validation [equal], Writing—original draft [lead], Writing—review & editing [lead]), Adam Lutz (Conceptualization [equal], Data curation [lead], Investigation [equal], Methodology [equal], Project administration [equal], Resources [equal], Validation [equal], Writing—original draft [supporting], Writing—review & editing [supporting]), Uchechukwu Ikeaba (Conceptualization [equal], Formal Analysis [equal], Investigation [equal], Methodology [equal], Validation [equal], Visualization [equal], Writing—original draft [supporting], Writing—review & editing [supporting]), Brooke Alhanti (Conceptualization [equal], Formal Analysis [lead], Investigation [equal], Methodology [equal], Software [equal], Supervision [equal], Validation [equal], Visualization [equal], Writing—original draft [equal], Writing—review & editing [supporting]), Steven Z. George (Conceptualization [equal], Investigation [equal], Methodology [equal], Resources [equal], Writing—original draft [equal], Writing—review & editing [equal]), Chad E. Cook (Conceptualization [equal], Investigation [equal], Writing—original draft [equal], Writing—review & editing [equal]), and Charles Thigpen (Conceptualization [equal], Data curation [equal], Methodology [equal], Writing—original draft [supporting], Writing—review & editing [supporting]).

SUPPLEMENTARY MATERIAL

Suppl. material is available online.

FUNDING

ATI Holdings, LLC provided funding for this analysis. ATI provided all data and input on the research question and study design. Duke University investigators designed the study, conducted the analysis, and were responsible for all reporting of this study, including development of the manuscript. ATI reviewed the manuscript only to ensure accuracy of the program description and Duke investigators had full scientific freedom to publish results.

ETHICS APPROVAL

The Duke University Institutional Review Board approved this study.

DISCLOSURE

The authors completed the ICMJE Form for Disclosure of Potential Conflicts of Interest and reported no conflicts of interest.

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DATA AVAILABILITY

Data are not publicly available.

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Physical Therapy, 2025, 105, pzaf129
https://doi.org/10.1093/ptj/pzaf129
Original Research

SB 699 Support - ROY FILM.pdf
Uploaded by: Roy Film
Position: FAV

Good afternoon, Madame Chair and members of the committee.

Thank you for the opportunity to speak in support of Senate Bill 699 which simply intend that PT copays are no higher than primary care copays for the same condition.

I'm Dr. Roy Film, an orthopaedic PT with 30 years of experience, a resident of Catonsville, and former owner of a private PT practice in Ellicott City. I am the President of APTA Maryland and an assistant professor at the University of Maryland School of Medicine. My research focuses on how PT can mitigate prescription opioid addiction.

The cost-analysis study commissioned during the previous attempt in Maryland at passing similar legislation did not include a cost-avoidance analysis. In other words, it was not a cost-benefit analysis at all. By assuming zero downstream savings, it modeled a completely unrealistic fictional scenario. Thankfully, we have more data now. A large, multistate, outpatient PT claims-based analysis published last year showed that eliminating copays, not just reducing them, still led to lower use of imaging, injections, surgery, and physician services.[1]

Since 2016, the CDC and the World Health Organization have recommended non-drug therapies, including PT, as first-line treatment for acute and chronic back pain. I've seen many times how patients who were scheduled for an elective orthopedic spine surgery were able to manage well enough with a supervised PT regimen that the surgeon canceled the surgery.

However, high PT copays create an artificial systemic barrier that drives people away from care – and this is intentional on the part of insurers. Without considering cost-avoidance, they are inadvertently driving patients away from cost-effective, evidence-based care. Unfortunately, these policies disproportionately impact families of lower financial means. These policies foster more chronic pain, more surgeries, more injections, more opioid use, and ultimately, more health inequity.

Lowering PT copays isn't "cherry picking". Physical therapy is evidence-based, cost-saving care. In over a dozen states that have enacted this type of legislation, we've seen no evidence of runaway utilization or cost shifting. It's time for us to finally catch up.

On behalf of thousands of physical therapists and all the Marylanders we serve, I respectfully urge a favorable report. Thank you for your time and consideration.

1. Lentz TA, Lutz A, Ikeaba U, Alhanti B, George SZ, Cook C, et al. Episode of Care Characteristics Following Implementation of a No-Copay Physical Therapy Program for Musculoskeletal Conditions. Phys Ther.2025;105(11). Descriptive claims-based analysis showing that a no-copay PT benefit was associated with lower use of advanced imaging, injections, surgery, and physician services compared to traditional pathways, informing benefit design and potential cost impact of lowering PT copays.

Zeeshan Fair copay bill testimony.pdf
Uploaded by: Zeeshan "Zee" Bhimani
Position: FAV

Zee APTA MD Fair copay bill testimony:

Good afternoon Madam chair and members of the committee. My name is Zeeshan Bhimani and I have been a Physical Therapist for 11 years working in different settings ranging from out patient, skilled nursing and home health. Currently I work as a home health PT in Montgomery county. I am also the Director of Reimbursement for APTA Maryland. I am here to urge a favorable report on SB 699.

Physical Therapy is a cumulative process . We work in conjunction with the biological healing process, which requires multiple visits over time to be effective. Due to the current co-pay system a 60-80$ copay per visit cumulatively leads to an out of pocket barrier of approximately 600$ per month for the patient. When the patient can't afford the dosage of the therapy they end up skipping visits and/or often stop treatment completely.

For instance, I had a patient who came to our clinic with complaints of low back pain, he received a few sessions of therapy but abruptly stopped, stating that his back pain was better and the high co-pays made it unaffordable for him to complete the recommended dosage. After a few months that patient came back, mentioning that he aggravated his pain again for which he had to go to the emergency room , get imaging and finally got a spinal injection which helped him with pain for a few months but had started wearing off. His Orthopedic recommended to continue managing the pain with Physical therapy. All this could have been avoided if the patient would have continued the recommended dosage and would have had a better outcome. Studies show that PT management gives a net cost benefit of $4,160 for acute low back pain.

This Fair co-pay bill will not only help lowering the fee, but will also help patients choose a path which is replacing expensive surgeries and injections with proven conservative care.

2026 MCA SB 699 PT Privileges bill.pdf
Uploaded by: Ashlie Bagwell
Position: FWA

MARYLAND
CHIROPRACTIC
ASSOCIATION

TESTIMONY ON BEHALF OF THE MARYLAND CHIROPRACTIC ASSOCIATION

Support with Amendments

Senate Bill 699—Health Insurance-Physical Therapy-Copayments, Coinsurance, and Deductibles

Senate Finance Committee

March 4, 2026

The Maryland Chiropractic Association (MCA) is a professional organization founded in 1928 and is the leading voice for chiropractors in Maryland. Comprised of individual members, our mission is to elevate the chiropractic profession by educating the public and advancing chiropractic care for the citizens of Maryland. We have weighed in on many issues concerning patient care, insurance and other issues of importance to our members as well as our patients and the general public.

Senate Bill 699 prohibits payors from imposing a copayment, coinsurance or deductible for covered physical therapy services that is greater than the copayment, coinsurance or deductible for a primary care visit under the same contract. While many chiropractors have PT privileges, this bill does not appear to explicitly cover them and the services they provide. Therefore, we would respectfully request an amendment to clarify that. Specifically, we would request the following language be added to page 2, line 2:

ARTICLE[.] <u>OR A CHIROPRACTOR WITH PHYSICAL THERAPY PRIVILEGES WHO IS LICENSED BY THE BOARD OF CHIROPRACTIC EXAMINERS UNDER THE HEALTH OCCUPATIONS ARTICLE.</u>

With this amendment, we respectfully request a favorable vote.

For more information or for questions, please call Don Hirsh, DC (301.442.3533) or Ashlie Bagwell (443.800.4506).