State Laws Limiting Patient Copayments for Physical Therapist Services

January 2020

Arkansas — 2013 — Act Number 342 (SB 277)

SECTION 1. Arkansas Code Title 23, Chapter 79, Subchapter 1, is amended to add an additional section to read as follows:

23-79-156. Payment for services rendered by physical therapists, occupational therapists and speech-language pathologists.

(a) As used in this section:

(1)(A) "Health benefit plan" means any group or blanket plan, policy, or contract for health care services issued or delivered in this state by health care 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 health care 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) "Health care 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.

(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.

Connecticut — 2013 — Public Act No. 13-307 (HB 6546)

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (Effective January 1, 2015) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes 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 physical therapy services rendered by a physical therapist licensed under section 20-73 of the general statutes.

Sec. 2. (NEW) (Effective January 1, 2015) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes 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 physical therapy services rendered by a physical therapist licensed under section 20-73 of the general statutes.

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.

    c. An individual or group health maintenance organization contract regulated under chapter 514B.

    d. A plan established pursuant to chapter 509A for public employees.

    e. An organized delivery system licensed by the director of public health.

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

Section takes effect July 2, 2015, and applies retroactively to July 1, 2015; 2015 Acts, ch 137, §162, 163

Kentucky — 2011 — Kentucky Revised Statutes 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.

Missouri — 2013 — 376.1235

1. No health carrier or health benefit plan, as defined in section 376.1350, shall impose a co-payment or co-insurance percentage charged to the insured for services rendered for each date of service by a physical therapist licensed under chapter 334, for services that require a prescription, that is greater than the co-payment or co-insurance 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 coverage under its plan and all related limitations, conditions, and exclusions.

3. Beginning September 1, 2013, 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 were enacted. By December 31, 2013, 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.

New Hampshire — 2014 — 1 New Section; Insurance; Individual; Copayments for Certain Providers.

Amend RSA 415 by inserting after section 6-r the following new section:

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 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.

2 New Section; Insurance; Group; Copayments for Certain Providers. Amend RSA 415 by inserting after section 18-w the following new section:

415:18-x Copayments, Coinsurance, or Office Visit Deductibles for Certain Providers. Each insurer that issues or renews any 2014 Patient Protection and Affordable Care Act of 2009, Public Law 111-148 - compliant small group policy of group or blanket accident or health insurance that constitutes health coverage for the services of chiropractors licensed under RSA 316-A, or physical therapists licensed under RSA 328-A, shall offer an optional plan which 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

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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.

3 Health Service Corporations; Copayments for Certain Specialists. Amend RSA 420-A:2 to read as follows:

420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6, II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-s, RSA 415:18, V, RSA 415:18, VII(g), RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA,415:18-x, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable provisions of title XXXVII wherein such corporations are specifically included. Every health service corporation and its agents shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.

4 Health Maintenance Corporations; Copayments for Certain Specialists. Amend RSA 420-B:20, III to read as follows:

III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-s, RSA 415:18, VII(g), RSA 415:18, VII-a, RSA,415:18, XVI and XVII, RSA 415:18-j, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA,415:18-x, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.

5 Applicability; Effective Date. The provisions of sections 1 and 2 of this act shall take effect and apply January 1, 2015 to health insurance plans effective on or after January 1, 2015 and sold exclusively off the federally-facilitated exchange. For health insurance plans sold through the federally- facilitated exchange and those same plans sold off the federally-facilitated exchange, the provisions of sections 1 and 2 shall take effect and apply January 1, 2016.

6 Health Services Corporations; Copayments for Certain Specialists. RSA 420-A:2 is repealed and reenacted to read as follows:

420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6, II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:18, V, RSA 415:18, VII(g), RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:22, RSA 417, RSA 417-E,

RSA 420-J, and all applicable provisions of title XXXVII wherein such corporations are specifically included. Every health service corporation and its agents shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.

7 Health Maintenance Corporations; Copayments for Certain Specialists. RSA 420-B:20, III is repealed and reenacted to read as follows:

III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:18, VII(g), RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-j, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.

8 Repeal. The following are repealed:

I. RSA 415:6-s, relative to copayments for certain providers.

II. RSA 415:18-x, relative to copayments for certain providers.

9 Effective Date.

I. Sections 1 and 2 of this act shall take effect as provided in section 5 of this act.

II. Sections 6-8 of this act shall take effect October 1, 2017.

III. The remainder of this act shall take effect 60 days after its passage.

Pennsylvania — 2015 — SB 487

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," providing for limits on copayments for insured medical services provided by a physical therapist, chiropractor and occupational therapist.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

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:

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.

"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.

Section 2. This act shall take effect in 60 days.

APPROVED—The 31st day of July, A.D. 2015.

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.

SL 2011, ch 217, § 1; SL 2012, ch 244, § 1.