LEGISLATIVE COMMITTEE MINUTES

SB123

Bill as Introduced

SB 123 - AS INTRODUCED

2021 SESSION

21-1016
05/10

SENATE BILL ***123***

AN ACT relative to copayments for COVID-19 testing.

SPONSORS: Sen. Sherman, Dist 24; Sen. Cavanaugh, Dist 16; Sen. Perkins Kwoka, Dist 21; Sen. Rosenwald, Dist 13; Sen. Whitley, Dist 15; Sen. Hennessey, Dist 1; Rep. Marsh, Carr. 8; Rep. Woods, Merr. 23

COMMITTEE: Health and Human Services

ANALYSIS

This bill waives cost-sharing for COVID-19 testing under accident and health insurance policies.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

21-1016
05/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to copayments for COVID-19 testing.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Accident and Health Insurance; Cost-Sharing for Testing for the Coronavirus (COVID-19) Waived; Individual. Amend RSA 415 by inserting after section 6-aa the following new section:

415:6-bb Cost-Sharing for Testing for the Coronavirus (COVID-19) Waived. Each insurer that issues or renews any individual policy of accident or health insurance providing benefits for medical or hospital expenses, shall waive cost-sharing for coronavirus (COVID-19) testing, including any out-of-network charges, for certificate holders of such insurance who are residents of this state.

2 New Section; Accident and Health Insurance; Cost-Sharing for Testing for the Coronavirus (COVID)-19 Waived; Group. Amend RSA 415 by inserting after section 18-ee the following new section:

415:18-ff Cost-Sharing for Testing for the Coronavirus (COVID-19) Waived. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, shall waive cost-sharing for coronavirus (COVID-19) testing, including any out-of-network charges, for certificate holders of such insurance, who are residents of this state.

3 Health Services Corporations; Applicable Statutes. 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-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:6-y, RSA 415:6-z, RSA 415:6-a1, ***RSA 415:6-bb,*** RSA 415:18, V, RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-i, 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-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:18-cc, RSA 415:18-dd, RSA 415:18-ee, ***RSA 415:18-ff,*** 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 Organizations; Statutory Construction. 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-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:6-y, RSA 415:6-z, RSA 415:6-a1, ***RSA 415:6-bb,*** RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, 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-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:18-cc, RSA 415:18-dd, RSA 415:18-ee, ***RSA 415:18-ff,*** RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.

5 New Paragraph; State Employees Health Insurance; Medical and Surgical Benefits. Amend RSA 21-I:30 by inserting after paragraph XVI the following new paragraph:

XVII. Medical and surgical benefits provided under this subdivision shall include waiving cost-sharing for testing for the coronavirus (COVID-19).

6 New Subparagraph; Medicaid Managed Care, Cost-Sharing for Certain Testing Waived. Amend RSA 126-A:5, XIX by inserting after subparagraph (k) the following new subparagraph:

(l) Managed care organizations shall waive all cost-sharing for coronavirus (COVID-19) testing for Medicaid recipients receiving care pursuant to this paragraph.

7 Effective Date.

I. Sections 1-4 of this act shall take effect July 1, 2021.

II. The remainder of this act shall take effect upon its passage.

SB 123 - AS AMENDED BY THE SENATE

03/11/2021 0621s

2021 SESSION

21-1016
05/10

SENATE BILL ***123***

AN ACT relative to employer payment of required COVID-19 testing.

SPONSORS: Sen. Sherman, Dist 24; Sen. Cavanaugh, Dist 16; Sen. Perkins Kwoka, Dist 21; Sen. Rosenwald, Dist 13; Sen. Whitley, Dist 15; Sen. Hennessey, Dist 1; Rep. Marsh, Carr. 8; Rep. Woods, Merr. 23

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill prohibits an employer from requiring that an employee or applicant for employment pay the cost of a COVID-19 test as a condition of employment.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 123 - AS AMENDED BY THE SENATE

03/11/2021 0621s

21-1016
05/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to employer payment of required COVID-19 testing.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Subdivision; COVID-19 Testing. Amend RSA 275 by inserting after section 77 the following new subdivision:

COVID-19 Testing

275:78 COVID-19 Testing. It shall be unlawful for any employer, as defined in RSA 275:4, to require any employee or applicant for employment to pay the cost of a COVID-19 test as a condition of employment.

2 Effective Date. This act shall take effect upon its passage.

Amendments

Sen. Prentiss, Dist 5
Sen. Sherman, Dist 24
February 17, 2021
2021-0414s
05/10

Amendment to SB 123

Amend the title of the bill by replacing it with the following:

AN ACT relative to employer payment of required COVID-19 testing.

Amend the bill by replacing all after the enacting clause with the following:

1 New Subdivision; COVID-19 Testing. Amend RSA 275 by inserting after section 77 the following new subdivision:

COVID-19 Testing

275:78 COVID-19 Testing. It shall be unlawful for any employer, as defined in RSA 275:4, to require any employee or applicant for employment to pay the cost of a COVID-19 test as a condition of employment.

2 Effective Date. This act shall take effect upon its passage.

2021-0414s

AMENDED ANALYSIS

This bill prohibits an employer from requiring that an employee or applicant for employment pay the cost of a COVID-19 test as a condition of employment.

Health and Human Services
March 3, 2021
2021-0621s
05/10

Amendment to SB 123

Amend the title of the bill by replacing it with the following:

AN ACT relative to employer payment of required COVID-19 testing.

Amend the bill by replacing all after the enacting clause with the following:

1 New Subdivision; COVID-19 Testing. Amend RSA 275 by inserting after section 77 the following new subdivision:

COVID-19 Testing

275:78 COVID-19 Testing. It shall be unlawful for any employer, as defined in RSA 275:4, to require any employee or applicant for employment to pay the cost of a COVID-19 test as a condition of employment.

2 Effective Date. This act shall take effect upon its passage.

2021-0621s

AMENDED ANALYSIS

This bill prohibits an employer from requiring that an employee or applicant for employment pay the cost of a COVID-19 test as a condition of employment.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Jeb Bradley, Chair
Sen James Gray, Vice Chair
Sen Kevin Avard, Member
Sen Tom Sherman, Member
Sen Rebecca Whitley, Member

Date: February 10, 2021

HEARINGS

Wednesday	02/10/2021
(Day)	(Date)

Health and Human Services	REMOTE 000	8:30 a.m.
(Name of Committee)	(Place)	(Time)

8:30 a.m.	**SB 120**	relative to physician assistant medical services through the Manchester Veterans Administration Medical Center.
8:45 a.m.	**SB 121**	relative to a state-based health exchange.
9:00 a.m.	**SB 123**	relative to copayments for COVID-19 testing.
9:30 a.m.	**SB 132-FN**	adopting omnibus legislation relative to COVID-19.

Committee members will receive secure Zoom invitations via email.

Members of the public may attend using the following links:

1. Link to Zoom Webinar: https://www.zoom.us/j/99818019001
2. To listen via telephone: Dial(for higher quality, dial a number based on your current location): 1-301-715-8592, or 1-312-626-6799 or 1-929-205-6099, or 1-253-215-8782, or 1-346-248-7799, or 1-669-900-6833
3. Or iPhone one-tap: US: +16465588656,,99818019001# or +13017158592,,99818019001#
4. Webinar ID: 998 1801 9001
5. To view/listen to this hearing on YouTube, use this link: https://www.youtube.com/channel/UCjBZdtrjRnQdmg-2MPMiWrA
6. To sign in to speak, register your position on a bill and/or submit testimony, use this link: http://gencourt.state.nh.us/remotecommittee/senate.aspx

The following email will be monitored throughout the meeting by someone who can assist with and alert the committee to any technical issues: remotesenate@leg.state.nh.us or call (603-271-6931).

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 120			
Sen. Sherman	Sen. Bradley	Sen. D'Allesandro	Rep. Marsh
Sen. Gray	Sen. Soucy	Rep. Knirk	
SB 121			
Sen. Rosenwald	Sen. Bradley	Sen. Sherman	Rep. Marsh
Rep. Bartlett	Rep. Weber	Rep. Hunt	
SB 123			
Sen. Sherman	Sen. Cavanaugh	Sen. Perkins Kwoka	Sen. Rosenwald
Sen. Whitley	Sen. Hennessey	Rep. Marsh	Rep. Woods
SB 132-FN			
Sen. Prentiss			

Kirsten Koch 271-3266

Jeb Bradley
Chairman

Senate Health and Human Services Committee

Kirsten Koch 271-3266

SB 123, relative to copayments for COVID-19 testing.

Hearing Date: February 10, 2021

Time Opened: 9:21 a.m. **Time Closed:** 10:02 a.m.

Members of the Committee Present: Senators Bradley, Gray, Avard, Sherman and Whitley

Members of the Committee Absent : None

Bill Analysis: This bill waives cost-sharing for COVID-19 testing under accident and health insurance policies.

Sponsors:

Sen. Sherman	Sen. Cavanaugh	Sen. Perkins Kwoka
Sen. Rosenwald	Sen. Whitley	Sen. Hennessey
Rep. Marsh	Rep. Woods	

Who supports the bill: Senator Sherman, District 24; Senator Perkins Kwoka, District 21; Senator Rosenwald, District 13; Senator Hennessey, District 1; Rep. Frost, Strafford 16; Holly Stevens, New Futures; Michael Padmore, NH Medical Society; Paula Minnehan, NH Hospital Association; Laura Acronson; Ashley Linane; Nicole Gugliucci; Elliot Cunningham; Elizabeth Lewis; Richard Denmark; Ruth Larson; Anne Grossi; Nicole Fordey; Haley Iwakiri.

Who opposes the bill: Andrew Hosmer, Harvard Pilgrim Health Care; Sabrina Dunlap, Anthem; Alexandra Menella.

Who is neutral on the bill: Tyler Brannen, NH Insurance Department.

Summary of testimony presented in support:

Senator Sherman, District 24

- Senator Sherman said, his constituents brought to him this concern about being asked to test for COVID-19 prior to being able to return to work and then having to pay for the testing. The testing does not fall under federal statute and was not covered by their insurance because the test was not medically necessary.
- The bill does still need a small amount of work; the fiscal note does have the concern of being so specific of employees, that it may take away from coverage for county employees, as one example, who get their tests paid by the state in-part and the county in-part.

Senator Prentiss, District 13

- Shared an anecdote about paying the cost sharing for her own COVID-19 test.

Holly Stevens, New Futures – provided written testimony

- Ms. Stevens provided testimony on the severity of COVID-19 virus.
- Ms. Stevens said, if a person has any COVID-19 symptoms, the NH Department of Health encourages that person to get tested. Given the deadly nature of this virus, and our knowledge that it is not going to be eradicated anytime soon, barriers to testing must be reduced or eliminated. This includes ensuring that commercial insurance products sold in New Hampshire do not charge a copay for COVID testing, in or out of network. While networks are a cost saving measure, a Granite Stater on vacation across the country should not be dissuaded from obtaining COVID testing simply because no in-network providers are close to them.
- SB 123 would save health care costs and the lives in Granite Staters.
- Ms. Stevens said, what we do not want is out-of-network providers to take advantage of this, or for someone to set up shop and run testing just to charge high rates and money.

Ms. Stevens spoke again after her initial testimony because she wanted to clarify the earlier discussions.

- Ms. Stevens said, entities like LabCorp require a doctor's order for testing. The standing order in place, under emergency order, allows for walk-in testing at pharmacies. Once the emergency is over, this goes away.
- Ms. Stevens asked the committee to please not delay this legislation another year because by then the emergency order will no longer be in effect and there will be a barrier to getting tested.

Summary of testimony presented in opposition:

Donald Pfundstein, AHIP

- Mr. Pfundstein shared a news article from USA Today from September 15, 2020 about out-of-network COVID-19 tests charging carriers unreasonably high rates, because they can get away with it.
- Mr. Pfundstein shared anecdote about a Texas physician that received a $10,000 COVID-19 test that his carrier had to pay the bill for.
- Mr. Pfundstein said, aside from the extremes, the average cost for a COVID-19 test is about $130.00. The average COVID-19 test done out-of-network costs about $185.00, which is 40% higher than the cost in-network, because out-of-network testing can get away with charging higher. Furthermore, 16% of out-of-network COVID-19 tests cost more than $390.00 per test. Out-of-network charges more for testing because they can, and now, the insurers are required to pay it.
- Mr. Pfundstein said, this bill addresses a problem, but that problem is not a problem in NH. If it has happened, call the carrier, and address it. They should cover the cost. It is an error if you are being charged cost sharing for a COVID-19 test.

Sabrina Dunlap, Anthem

- Ms. Dunlap says, we, Anthem, respectfully question the need to put this into statute. This is covered by federal lab and the NH Insurance Department (NHID).

- Anthem waived copays on COVID-19 tests for their enrollees. Anthem fully supports waiving cost sharing for testing.
- Agencies like NHID respond quickly, which is what we need in an ever-evolving pandemic.
- Senator Bradley said, there has not been any cost sharing. You take a test and get tested without copay. Is that not true?
    - Ms. Dunlap said, that is correct. If ordered by a provider, Anthem is waiving all cost sharing, at this point, for the testing.
- Senator Bradley said, what if the test is not ordered by a provider?
    - Ms. Dunlap said, as far as I know, if you go get a test, it is covered without cost sharing. I am not sure if it makes a difference who orders it. I think SB 132-FN gets at this more.

Ms. Dunlap later testified for a second time to provide clarification.

- Ms. Dunlap said, the NHID refers the any issues made known to them by enrollees to the carrier. It is always a billing issue if you must pay cost sharing for a COVID-19 test. Please call NHID or your carrier if you think there is a billing error.
- Senator Bradley asked for clarification.
    - Ms. Dunlap said, nobody should be paying co-pay, or billed cost sharing, for COVID-19 testing.

Neutral Information Presented:

Tyler Brannen, NH Insurance Department (NHID) – provided written testimony

- Mr. Brannen stated that the NHID has no position on this bill, but the NHDI did want to express some concerns.
- There is an insurance requirement for network adequacy. This includes lab testing. If there are no local providers in-network, the carrier needs to cover the testing (all services, not just COVID-19 testing).
- The NHID does oppose the requirement for coverage for out-of-network testing. The quality of the test could be unfavorable.
- Mr. Brannen shared an anecdote about a NY Times article that reported on $6,000 COVID-19 tests. Mr. Brannen said paying out-of-network creates additional charges for carriers. This creates a great opportunity for companies to take advantage of polices like this to make money. Please remove that and rely on what we have created already from the department.
- Mr. Brannen said, agents have access to national chains, such as LabCorp, that are in-network providers with agreements. Contact your insurance company to ask where you get a covered COVID-19 test if you are away from home, or on vacation.
- Senator Whitley asked, are you aware of any sites in NH that are currently charging co-pays?
    - Mr. Brannen, some are tied to ACA products, Department of Labor requirements, or patchwork requirements.
- Senator Sherman, what evidence backs up your testimony today?

- Mr. Brannen said, the reports in the media. The federal requirements are limited. Providers should put up the cost for the tests. But some do not. We do not know anything about these out-of-network providers.

- Senator Sherman said, this bill really is needed, is what you are saying, because there is not adequate federal protection.
  - Mr. Brannen said, no. This would allow tests of unreasonably high costs to be paid by the carrier. When someone learns about legislation like this, we run into problems because enrollees stop going to in-network providers, which rises the costs for carriers.
- Senator Whitley said, wouldn't you agree we should remove any barriers for low-income folks, and remove any barriers for getting tests? We should work to improve the public health crisis.
  - Mr. Brannen said, there is a consistent legislative intent to be concerned with the cost of health insurance. If you open the doors to allow out-of-network, this drives up the health insurance premiums. There are consumer protections that have provided access already.
- Senator Whitley said, we need to get back to being open. Personally, I would rather save lives. Could we put in some cost protections in this bill would that satisfy your concern?
  - Mr. Brannen said, that would add a layer of protection, but I am not sure that would control out-of-network providers, because they can do whatever they want to take advantage of this legislation.
- Senator Bradley, you cited the NY Times articles for a $6,000 test. When and where was this?
  - Mr. Brannen said, this was not in NH and not in the last month.
  - Mr. Brannen later sent the committee the NY Times article.
- Senator Bradley said, are you aware of anybody in or out-of-network outside of NH that had to pay any cost sharing for a COVID-19 test?
  - Mr. Brannen said, only when there has been a billing error.
- Senator Bradley said, I could see merit to this bill if people were having to pay cost sharing in NH. Sounds like the only people who see cost sharing are people who get a tested outside of NH, outside of their carrier, but even then, it sounds like it is covered.
  - Mr. Brannen said, it is covered without cost sharing.
- Senator Sherman said, would you believe--without mentioning names--that a Senator was billed $150.00 for a COVID-19 test? It is happening in NH. What is the process for remedying this?
  - Mr. Brannen said, I am surprised to hear that. The NHID is following consumer complaints and speaking with carriers. The type of coverage people have may vary. We have had a few billing errors come up.
- Senator Sherman, what is the formal appeals process for someone who is aggrieved with paying co-pays on COVID-19 tests?
  - Mr. Brannen said, start with consumer services online or by phone.

KNK
Date Hearing Report completed: February 16, 2021

Speakers

Name	Title	Representing	Position	Testifing
Brannen Tyler	State Agency Staff	Insurance Department	Neutral	Yes
Sherman Senator Tom	An Elected Official	SD24	Support	Yes
Dunlap Sabrina	A Lobbyist	Anthem	Oppose	Yes
Stevens Holly	A Lobbyist	New Futures	Support	Yes
Mennella Alexandra	A Member of the Public	Myself	Oppose	No
Aronson Laura	A Member of the Public	Myself	Support	No
Linane Ashley	A Member of the Public	Myself	Support	No
Gugliucci Nicole	A Member of the Public	Myself	Support	No
Hosmer Andrew	A Lobbyist	Harvard Pilgrim Health Care	Oppose	No
Cunningham Elliott	A Member of the Public	Myself	Support	No
Frost Sherry	An Elected Official	Myself	Support	No
Lewis Elizabeth	A Member of the Public	Myself	Support	No
Padmore Michael	A Lobbyist	NH Medical Society	Support	No
demark richard	A Member of the Public	Myself	Support	No
Rosenwald Cindy	An Elected Official	SD 13	Support	No
Grossi Anne	A Member of the Public	Myself	Support	No
Fordey Nicole	A Member of the Public	Myself	Support	No
Minnehan Paula	A Lobbyist	NH Hospital Association	Support	No
Iwakiri Haley	A Member of the Public	Myself	Support	No
Larson Ruth	A Member of the Public	Myself	Support	No
Perkins Kwoka Senator Rebecca	An Elected Official	Myself (SD 21)	Support	No
Hennessey Erin	An Elected Official	SD1	Support	No

Testimony

February 10, 2021

The Honorable Jeb Bradley, Chair
Senate Health, Human Services Committee
State House Room 100
Concord, NH 03301

Re: New Futures' testimony in support of SB 123

Dear Chairman Bradley and Members of the Committee:

New Futures appreciates the opportunity to testify in support of SB 123, relative to copayments for COVID-19testing. New Futures is a nonpartisan, nonprofit organization that advocates, educates, and collaborates to improve the health and wellness of all New Hampshire residents. In this role, we work extensively with policy makers, health care providers and families to improve overall public health and improve health equity across the Granite State.

The COVID pandemic is the worst we have seen in modern history. Not only is it deadly, it is impossible to predict how it will affect a single individual once he or she is infected. In some cases, the virus is very quick to render a person defenseless, and they succumb to the illness. Unfortunately, the symptoms of COVID are very similar to several other viruses, making it impossible for a person to know if they have been infected by COVID or some other illness. New Hampshire's Department of Public Health has said over and over that if a person has any of COVID's symptoms, they should get tested. Even people who have been vaccinated are encouraged to get tested if they develop any COVID symptoms. Given the state's encouragement of and opinion regarding COVID testing, there should be no barriers that have a chilling effect on people seeking a test.

Research shows that copays, even small ones, can discourage a person from seeking needed medical care. According to the Commonwealth Fund, one study found that a copay as low as $12.50 discouraged women from obtaining mammograms. Without doing appropriate research, it is impossible to know what the "sweet-spot" would be for a COVID test copay. Given the deadly nature of this virus, and our knowledge that it is not going to be eradicated anytime soon, barriers to testing must be reduced or eliminated. This includes ensuring that commercial insurance products sold in New Hampshire do not charge a copay for COVID testing, in or out of network. While networks are a cost saving measure, a Granite Stater on vacation across the country should not be dissuaded from obtaining COVID testing simply because no in-network providers are close to them.

Simply put, given the unpredictable and deadly nature of the COVID-19 virus and the chilling effect copays would have on testing, SB 123 would go a long way in saving health care costs and lives of Granite Staters. Included with this written testimony are two resources regarding the deterrence of copays and cost sharing on obtaining necessary health care services for your review.

For all the reasons stated above, New Futures strongly urges the Committee to vote Ought to Pass on SB 123.

Please do not hesitate to contact me if you have any questions.

Respectfully submitted,

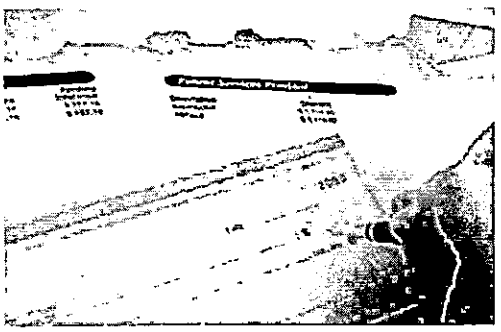
Holly A. Stevens, Esq.
Health Policy Coordinator

The Commonwealth Fund

Hitting the Copay Sweet Spot

By Brian Schilling

Medical copayments—that is, the $5 to $30 you're charged every time you go to the doctor or fill a prescription—are not unlike certain drugs: effective, but often improperly used. It's no surprise, really. The science of designing and applying copays across different drugs, services, and populations is still part art. According to Dr. Michael Chernew, of Harvard Medical School, who serves on The Commonwealth Fund's Commission on a High Performance Health System and has years of experience studying benefit design, hard and fast rules don't exist. But that doesn't excuse you from putting some thought into your company's copay structure. Does it discourage the use of low-value procedures? Is it barring access to sensible preventive care and screenings? Is a $5 copay even meaningful anymore?



Getting the copay structure just right will always involve some tinkering since every company and every covered population is different. Even if your company's benefits were created with the principles of **value-based benefit design** in mind, plan on making changes periodically. The right copay levels one year might not be the right levels the next year, as new drugs, therapies, and health issues emerge. While there may not be any hard and fast rules to guide you, Purchasing High Performance can offer a few simple guidelines for fine tuning your company's copays:

The $5 copay is not irrelevant. Study after study has shown that the $5 copayment generally does have the expected impact of lowering utilization. Thus, the oft-encountered $5 copay should be applied judiciously—do you really want to reduce utilization of drugs

that help those with chronic illnesses manage their conditions? Be advised that $5 is sometimes too much. Zero is the right amount for high-value preventive care. In some instances, it may even make sense to pay employees to seek care or a particular immunization. Ask yourself, how much you would be willing to spend to make sure your employees were protected from the swine flu?

The copay should never be a blunt instrument. The idea that a copay of any amount should be applied evenly across all drugs, all services, or even to all employees is obsolete. Copays should be kept very low or eliminated for low-cost, high-value services and drugs. High copays are perfectly acceptable for medically non-indicated or frequently overused services or for high-cost drugs, if less expensive, equally effective alternatives are available.

Copays affect different populations differently. Race, gender, age, economic status, and medical condition are all relevant factors to consider when setting copayments. Consider who your employees are and make absolutely sure that copays are not discouraging them from seeing needed, appropriate care. One study, for example, found that copays as low as $12.50 were enough to (inadvertently) deter women from getting needed mammograms.[1] Another found that copays of no more than $15 were sufficient to drastically reduce the use of necessary and appropriate children's health services.[2]

Copays affect utilization of different drugs and services differently. One study found that increasing the office visit copay by $10 reduced utilization by nearly 20 percent, but the same study found that increasing prescription copays by just $1 reduced utilization by over 20 percent.[3] A 2008 study found that reducing copays to $5 (from about $11) increased medication compliance by 7 percent to 14 percent among patients with several chronic illnesses.4 The bottom line: test the effect your copay is having and adjust it accordingly.

The deductible is part of the same equation. According to Dr. Chernew, you must consider the deductible and the copayment together. The deductible is the amount you pay out of pocket before your insurance will pay anything. It can range from zero to thousands of dollars, depending on the plan. The presence of a high deductible may negate or counteract the effect of a lowering a plan's copayment.

Tinker, but tinker with an actuary. Don't expect that your copay structure is OK as it is, no matter how much effort you put into devising it. Review your claims and consider where there might be waste or overutilization. Does a higher copay make sense there? Think also about underutilization. What drugs or services should be free? Dr. Chernew estimates that of 100 randomly chosen companies, no more than five have done a good job of setting copays that reflect the tenets of value-based insurance design (see **related article**). Engage

the services of a health actuary or other professional to help guide your efforts. Expertise and experience will streamline the process of developing a copay structure that does what you want it to do.

For further reading and resources on the art and science of using copays to control costs and increase quality, see the links below.

Links:
NBCH's Value Based Benefit Design Purchaser Guide
http://www.nbch.org/documents/VBBDPurchaserGuide.pdf

The Center for Value Based Insurance Design
http://www.sph.umich.edu/vbidcenter/

Citations:
[1] A. N. Trivedi, W. Rakowski, and J. Z. Ayanian, "Effect of Cost Sharing on Screening Mammography in Medicare Health Plans," New England Journal of Medicine, Jan. 24, 2008 358(4):375–383.
[2] "Increase In Drug Copay Boosts Odds That Older Adults Will Cut Back Or Stop Taking Medications, Finds Study Presented At American Geriatrics Society," Medical News Today, May 5, 2008, http://www.medicalnewstoday.com/articles/106145.php.
[3] A. Chandra, J. Gruber, and R. McKnight, Patient Cost-Sharing, Hospitalization Offsets, and the Design of Optimal Health Insurance for the Elderly, National Bureau of Economic Research Working Paper #12972, (Cambridge, Mass.: National Bureau of Economic Research, March 2007).
[4] M. E. Chernew, M. R. Shah, A. Wegh et al., "Impact of Decreasing Copayments on Medication Adherence within a Disease Management Environment, Health Affairs, Jan./Feb. 2008 27(1): 103–112.

Publication Details

The Commonwealth Fund

Effects of Cost Sharing on Care Seeking and Health Status: Results From the Medical Outcomes Study

Mitchell D. Wong, MD, PhD, Ronald Andersen, PhD, Cathy D. Sherbourne, PhD, Ron D. Hays, PhD, and Martin F. Shapiro, MD, PhD

Objectives. This study sought to determine the effect of cost sharing on medical care use for acute symptoms and on health status among chronically ill adults.

Methods. Data from the Medical Outcomes Study were used to compare (1) rates of physician care use for minor and serious symptoms and (2) 6- and 12-month follow-up physical and mental health status among individuals at different levels of cost sharing.

Results. In comparison with a no-copay group, the low- and high-copay groups were less likely to have sought care for minor symptoms, but only the high-copay group had a lower rate of seeking care for serious symptoms. Follow-up physical and mental health status scores were similar among the 3 copay groups.

Conclusions. In a chronically ill population, cost sharing reduced the use of care for both minor and serious symptoms. Although no differences in self-reported health status were observed, health plans featuring cost sharing need careful monitoring for potential adverse health effects because of their propensity to reduce use of care that is considered necessary and appropriate. (*Am J Public Health.* 2001;91:1889–1894)

Requiring patients to pay a portion of their medical bill out of pocket, also known as cost sharing, sharply reduces their use of health care resources.[1–9] Use of this strategy by health insurance plans to lower expenditures is controversial: proponents argue that health care consumers will appropriately ration their use of medical services; critics fear that this financial disincentive will lead patients to use less care that may be necessary and will result in worse health outcomes.

The RAND Health Insurance Experiment, which randomized subjects to health plans with varying coinsurance levels, did not provide a definitive judgment in regard to these issues. Relative to free care, coinsurance reduced use of both unnecessary and necessary care[1,4] but had only a small adverse effect on health outcomes.[1,10,11] Because the study excluded disabled and elderly individuals, subjects may have been too healthy for a greater negative health effect to be observed. Thus, we analyzed data from the Medical Outcomes Study, which prospectively followed chronically ill adults, to determine whether cost sharing deters use of care and leads to subsequent worse health outcomes among a population whose health may be more vulnerable to use disincentives.

METHODS

Study Design

In the Medical Outcomes Study, designed to examine the impact of different systems of care on health outcomes, adults with 1 or more chronic illnesses were followed over 4 years. Site, physician, and subject selection methods have been described elsewhere.[12,13] A multistage sampling technique was used in which physician practices were selected first, followed by physicians and, finally, patients. Patients who visited one of the selected physicians' offices during a 2-week recruitment period between February and October 1986 were asked to participate in a cross-sectional survey. Eligible subjects (English-speaking individuals 18 years or older) and their physicians were asked to complete a brief screening survey.

Of 28 257 patients who were approached, 20 222 (71.6%) agreed to participate; in the case of 18 974 (67.1%) of these patients, both the patient and his or her physician completed the forms. Through use of the data from the screening survey and an additional telephone interview, 3589 individuals with 1 or more chronic conditions (diabetes, hypertension, coronary heart disease, congestive heart failure, depression) were identified as potential subjects for a 4-year prospective cohort study. Of these patients, 2546 were randomly selected and agreed to participate.

Study Sample

We analyzed data from the 1700 (67%) subjects who completed the 12- and 18-month surveys, which assessed individuals' level of cost sharing and use of medical care. The remaining 846 subjects were excluded because they did not complete both surveys or were completely lost to follow-up for a variety of reasons, including refusals, failure to contact, and death.

The included and excluded groups were similar in regard to sex, race/ethnicity, education, and annual income but differed in several other respects. In comparison with nonparticipants, participants were older (57.1 vs 54.2 years; $P=.0001$), more likely to be married (59% vs 52%; $P=.002$), slightly less likely to be employed (48% vs 52%; $P=.08$), and more likely to have a prepaid health plan (43% vs 31%; $P=.001$). The 2 groups had comparable comorbidity scores and Short Form-36 (SF-36)[14] physical health status scores, but the study sample had slightly better SF-36 mental health scores (48.7 vs 46.3; $P<.001$).

Data Collection

At baseline and every 6 months, subjects were asked to fill out a questionnaire asking about mental and physical health status, use of medical services, annual family income, and insurance. As a means of assessing level of cost sharing for an outpatient visit, subjects were asked "Besides your deductible, how much does your insurance plan pay for a doctor visit for a medical problem?" Response choices were "none," "some," "half," "most," and "all." This response scale was reversed so that the question would reflect how

much the individual paid. For example, subjects whose response was "all" were categorized as having no cost sharing, and subjects whose response was "none" were categorized as being responsible for 100% of the cost of an outpatient visit.

Given the small number of responses for some options, we collapsed individuals into 3 cost-sharing categories: no copay (insurance pays all), low copay (insurance pays more than half but not all), and high copay (insurance pays half or less). Using insurance and employment data, we conducted logistic regression analyses to impute missing data on level of cost sharing for 92 (5.4%) subjects.

We measured use of medical services for minor and serious symptoms by asking subjects whether they had experienced and sought medical care for any of 5 listed minor symptoms or 8 serious/morbid symptoms in the preceding 4 weeks. The minor symptoms were nasal congestion for less than 2 weeks, rash for less than 3 weeks, ankle swelling at the end of the day, stomach upset for less than 24 hours, and cough without fever for less than a week. The serious and morbid symptoms were loss of consciousness, bleeding other than from the nose or caused by accidents or menstruation, abdominal pain that caused awakening for more than 1 night, burning on urination for more than 2 days, weakness on one side of the body or loss of speech, shortness of breath in the middle of the night, chest pain brought on by activity, and more than 4 bowel movements per day for more than 2 weeks.

Of the 13 symptoms just described, 8 were examined in a recent study involving a national sample of physicians who rated the seriousness of the symptoms.[15] On a 10-point scale in which higher values represented greater seriousness, average ratings were 2.8 for minor symptoms and 7.0 for serious and morbid symptoms.

To measure health status, we used the SF-36 physical and mental health summary scales.[14] Summary scores can range from 0 to 100 and are scaled so that the mean of a representative US general population is 50 with a standard deviation of 10. Summary scores for some individuals were missing because of 1 or more missing subscale scores. We conducted a least squares regression analysis involving nonmissing subscale scores to impute missing summary health status scores.

To calculate comorbidity scores, we used an unweighted count of 16 different chronic conditions, including the 5 chronic conditions required for eligibility in the cohort study. The other 11 chronic conditions were cancer, arthritis, major neurologic deficit, use of a cardiac pacemaker, amputated limb, chronic pulmonary disease, chronic back pain, peptic ulcer disease, chronic inflammatory bowel syndrome, kidney disease, and difficulty seeing. Satisfaction with general health care was assessed via a validated measure created for the Medical Outcomes Study.[16,17]

In the remainder of this article, we refer to the 12-month questionnaire, the point at which cost-sharing status was first assessed, as time 0 and to the subsequent 18-month and 24-month questionnaires as time 1 and time 2, respectively. Use of medical care for minor and serious symptoms was assessed at time 1, and health status was measured at all 3 points.

Statistical Analysis

We performed bivariate comparisons of the 3 cost-sharing groups in regard to demographic characteristics, type of health insurance coverage, comorbidity score, baseline mental and physical health status, and satisfaction with medical care. Chi-square statistics were used to compare differences in proportions among categoric variables, and factorial analysis of variance (ANOVA) statistics were used to examine differences in means.

We used Mantel–Haenszel χ^2 statistics to test for trends in the proportions of each group of subjects who sought care for minor and serious symptoms among those who reported having symptoms.[18] Individuals were categorized as having sought care if they reported seeking medical care for at least 1 of the symptoms. For example, subjects who had experienced 2 symptoms but had sought care for only 1 of them were categorized as having sought care for their symptoms. In addition, we conducted separate analyses for minor and serious symptoms.

We performed a multiple logistic regression analysis to adjust for subjects' demographic characteristics, insurance type, physical and mental health status, and satisfaction with care. Because individuals who experienced more symptoms would be more likely to have sought medical care, we also controlled for the number of symptoms experienced. We added an interaction term between income and level of cost sharing to the multivariable models because we hypothesized that cost sharing might have a greater effect among those with lower incomes; however, this interaction term was not a significant predictor, and we excluded it from the final models.

We conducted 2 sensitivity analyses. First, we repeated our analysis but excluded subjects with Medicaid or no insurance, because their greater likelihood of having additional unmeasured barriers to care could have confounded our findings. Our results were robust and were not substantially changed when these individuals were excluded. Second, we excluded individuals with selected chronic conditions who might have had different medical care needs for certain symptoms. For example, the necessity of medical care for chest pain is likely to be different for individuals with and without coronary artery disease. Similarly, the presence of chronic pulmonary disease might influence the need to seek care for dyspnea. Our results were unchanged after we excluded individuals with a history of cardiac and pulmonary disease.

Finally, using factorial ANOVA statistics, we compared physical and mental health status scores at time 1 and time 2 among the 3 cost sharing groups. We then used analysis of covariance (ANCOVA)[19] to compare the 3 copay groups in regard to health status scores at time 1 and time 2, adjusting for health status at time 0 and other potential confounders. An interaction term between income and cost sharing was found not to be a statistically significant predictor of health status and thus was not included in the final ANCOVA models.

We weighted all analyses to account for the original sampling strategy.[20] Sensitivity analyses excluding observations with imputed values revealed no differences in any of our results. No statistical outliers or influential points were found in any of the multivariable models.[21,22] SAS software was used for all analyses.[23]

TABLE 1—Comparison of Baseline Characteristics, by Level of Cost Sharing: Medical Outcomes Study

	Cost-Sharing Level			
	None (n=824)	Low (n=611)	High (n=265)	*P*
Mean age, y (95% CI)	58.7 (57.6, 59.8)	54.8 (53.6, 56.1)	57.4 (55.4, 59.5)	.001
Females, %	60	63	60	...
Minority, %	25	12	24	.001
Married or has a partner, %	63	66	54	.001
Graduated high school, %	78	86	75	.001
Employed, %	38	48	39	.001
Mean annual family income[a] (95% CI)	20.3 (19.3, 21.3)	23.5 (22.3 , 24.7)	20.0 (17.9, 22.2)	.001
Insurance status, %				.001
Uninsured	0.5	5	2	...
Medicaid	16	6	9	...
Prepaid health plan	68	21	16	...
Fee for service	16	68	74	...
Mean comorbidity score (95% CI)	2.0 (1.9, 2.1)	1.9 (1.8, 2.0)	1.9 (1.8, 2.1)	>.2
Mean physical health status score (95% CI)	42.6 (41.8, 43.4)	43.6 (42.7, 44.6)	43.1 (41.6, 44.6)	>.2
Mean mental health status score (95% CI)	50.4 (49.6, 51.1)	49.0 (48.1, 49.9)	48.9 (47.6, 50.3)	.05
Mean general satisfaction score (95% CI)	6.5 (6.4, 6.7)	6.5 (6.4, 6.7)	6.5 (6.3, 6.7)	>.2

Note. CI = confidence interval.
[a]$1000s in 1986 dollars.

RESULTS

Of the 1700 subjects, 48% reported having no cost sharing (no-copay group) for an outpatient visit, as compared with 16% who reported that they paid half or more of their outpatient medical bill (high-copay group) and 36% who reported that they paid some but less than half of their medical bill (low-copay group). The low-copay group members were the youngest ($P<.001$) and had the highest incomes ($P<.001$), and this group included the smallest proportion of minorities ($P<.001$; see Table 1). The low-copay group also included the largest proportions of individuals who were married or living with a partner ($P<.001$), had graduated from high school ($P<.001$), and were employed ($P<.001$).

The 3 copay groups were also different in terms of their insurance coverage ($P<.001$). Of the no-copay group members, 68% had a prepaid health plan, in comparison with 21% of the low-copay group members and 16% of the high-copay group members. In contrast, the low- and high-copay groups were most likely to have fee-for-service health insurance (68% and 74%, respectively). Only a small proportion of the total sample was uninsured (2%) or had Medicaid coverage (11%).

Effect of Cost Sharing on Seeking Care

Among those who reported symptoms, the unadjusted percentages of subjects who sought medical care for minor and serious symptoms were 29% and 30%, respectively. For both types of symptoms, decreasing gradients for seeking care were found with higher levels of cost sharing. The unadjusted rates of care seeking for minor symptoms were 34% for the no-copay group, 26% for the low-copay group, and 18% for the high-copay group ($P=.001$). Unadjusted care seeking rates for serious symptoms were 33%, 31%, and 18% for the no-, low-, and high-copay groups, respectively ($P=.05$). This monotonic relationship between cost sharing and seeking care for symptoms remained unchanged after adjustment for other demographic and health variables.

In the weighted multivariable regression analyses, both the low- and high-copay groups were less likely to seek care for minor symptoms than the no-copay group (low-copay group: odds ratio [OR]=0.80, $P=.03$; high-copay group: OR=0.39, $P=.0001$) (Table 2). Regarding serious symptoms, the high-copay group was less likely to seek care than the no-copay group (OR=0.22, $P=.0001$), but the low- and no-copay groups did not differ (OR=0.80, $P=.15$). The multivariable analysis also showed that being married, employed, and uninsured; having a higher income; and being in better physical health were associated with a lower likelihood of seeking care for minor symptoms. Those who were older, male, White, and unemployed; had fee-for-service health insurance coverage; and had higher comorbidity scores were more likely to have sought care for serious symptoms.

Effect of Cost Sharing on Health Status

To examine the impact of cost sharing on health status, we examined the SF-36 physical and mental health summary scores of individuals at time 1 and time 2, controlling for health status at time 0. The 3 cost-sharing groups had similar unadjusted physical and mental health status scores at time 1 and time 2. After adjustment for baseline health status, comorbidity score, demographic

TABLE 2—Adjusted Odds Ratios for Predictors of Seeking Care for Minor and Serious Symptoms: Medical Outcomes Study

	Sought Care for Minor Symptoms (n = 1052)		Sought Care for Serious Symptoms (n = 529)	
Predictor Variable	OR (95% CI)	P	OR (95% CI)	P
Level of cost sharing				
None	1.0 ...	...	1.0 ...	...
Low	0.80 (0.65, 0.97)	.03	0.80 (0.58, 1.08)	.15
High	0.39 (0.29, 0.52)	<.001	0.22 (0.13, 0.36)	<.001
Age[a]	1.02 (0.96, 1.08)	>.2	1.11 (1.01, 1.22)	.03
Male	1.18 (0.99, 1.40)	0.07	1.40 (1.07, 1.83)	.02
Minority	1.11 (0.90, 1.37)	>.2	0.59 (0.43, 0.83)	.002
Married or has a partner	0.72 (0.60, 0.86)	<.001	0.91 (0.70, 1.19)	>.2
Graduated high school	1.18 (0.96, 1.46)	.12	0.97 (0.71, 1.33)	>.2
Employed	0.77 (0.63, 0.95)	.01	0.49 (0.36, 0.67)	<.001
Income[b]	0.91 (0.86, 0.96)	.002	0.96 (0.86, 1.06)	>.2
Insurance type				
Fee for service	1.0 ...	...	1.0 ...	...
No insurance	0.20 (0.07, 0.56)	.002	0.50 (0.23, 1.09)	.08
Medicaid	0.90 (0.74, 1.31)	>.2	0.68 (0.46, 1.00)	.05
Prepaid health plan	0.98 (0.81, 1.20)	>.2	0.65 (0.48, 0.88)	.005
Satisfaction with care[c]	1.02 (0.97, 1.06)	>.2	1.06 (0.98, 1.13)	.13
Comorbidity score	1.08 (1.00, 1.16)	.06	1.15 (1.04, 1.27)	.006
Physical health[c]	0.95 (0.91, 1.00)	.04	0.97 (0.90, 1.04)	>.2
Mental health[c]	1.01 (0.96, 1.06)	>.2	0.99 (0.92, 1.06)	>.2

Note. Odds ratios (ORs) are also adjusted for the number of symptoms experienced by the individual. CI = confidence interval.
[a]In 10-year increments.
[b]Annual family income in $10 000 increments.
[c]Based on a 10-point scale.

characteristics, insurance type, and satisfaction with care, follow-up physical and mental health status remained similar among the 3 groups (Table 3). Of note, lower income was a predictor of worse follow-up physical and mental health status at time 1 in our multivariable models, but no interaction effect between income and cost sharing was found.

DISCUSSION

Unlike cost-controlling strategies, such as drug formulary restrictions and use reviews, that target the behavior of physicians or medical groups, cost sharing is directly aimed at consumers. It encourages individuals to ration their health care, leading some to worry that cost sharing might threaten people's health. This concern is based on the assumptions that (1) individuals may not always distinguish between necessary and unnecessary care and (2) forgoing necessary medical care will worsen health.

Although previous studies have examined populations that included some chronically ill individuals (e.g., the Medicaid and Medicare populations),[24–26] the present study is the first to examine the impact of cost sharing in a cohort of older adults specifically selected because they had 1 or more chronic illnesses. In this study, both low and high levels of cost sharing, in comparison with no cost sharing, were associated with less use of medical care for minor symptoms. Cost sharing was also associated with lower rates of seeking care for serious symptoms, but only at the highest cost-sharing level.

These findings suggest that the demand for care for serious symptoms is less sensitive to price than that for minor symptoms and indicate that older, chronically ill individuals distinguish between more and less necessary care. This is significant because existing literature on the subject has been mixed. The RAND Health Insurance Experiment[4] and the Access-to-Care Study[7] showed that cost sharing reduces the use of care for minor symptoms; however, these 2 studies revealed different effects on use of care for serious symptoms. In the RAND Health Insurance Experiment, cost sharing had a marginal effect among individuals seeking care for serious symptoms, but in the Access-to-Care Study those with out-of-pocket payments greater than $30 exhibited significantly less use of care for serious symptoms.

Although individuals in the Medical Outcomes Study demonstrated some ability to distinguish between more and less necessary care, many were subjected to sufficiently high costs that their use of more necessary care was diminished. Our results are more consistent with those of the Access-to-Care Study and provide additional evidence that high levels of cost sharing deter the use of medical care that may be considered more appropriate and necessary.

Previous studies have demonstrated little or no impact of cost sharing on health outcomes, but these studies have not primarily involved individuals who are chronically ill and, thus, particularly vulnerable. In contrast, the Medical Outcomes Study was designed to examine an older, chronically ill population and involved subjects who had diabetes, hypertension, coronary artery disease, congestive heart failure, or depression. In addition, 46% of these subjects were older than 62 years (the upper age cutoff for inclusion in the RAND Health Insurance Experiment). We hypothesized that cost sharing would have a significant negative impact on health status in this sample owing to the subjects' advanced age and greater disease burden.

We found no association between cost sharing and health status at baseline or follow-up. Other studies of cost sharing examining acutely ill individuals have also failed to observe any negative health effect from cost sharing.[9,27] This lack of finding is particularly surprising given that the RAND Health Insurance Experiment involved a comparatively younger and healthier population and revealed a small yet statistically significant effect on health. One explanation may be re-

TABLE 3—Unadjusted and Adjusted Physical and Mental Health Status Scores, by Level of Cost Sharing: Medical Outcomes Study

	Level of Cost Sharing		
	None Mean (95% CI)	Some Mean (95% CI)	Half or More Mean (95% CI)
Adjusted physical health status[a]			
Time 1	41.6 (41.1, 42.1)	41.0 (40.3, 41.6)	41.1 (40.2, 42.1)
Time 2	42.6 (42.0, 43.2)	42.7 (42.0, 43.5)	42.5 (41.4, 43.5)
Adjusted mental health status[b]			
Time 1	48.9 (48.4, 49.5)	50.1 (49.4, 50.9)	49.8 (48.7, 50.9)
Time 2	50.9 (50.3, 51.5)	51.2 (50.4, 52.0)	52.0 (50.7, 52.8)

Note. Health status measured at time 1 and time 2 refers to SF-36 summary health status measured on the 18- and 24-month follow-up questionnaires, respectively. CI = confidence interval.
[a] Adjusted for physical health status at the 12-month follow-up (time 0), demographic characteristics, insurance type, comorbidity score, mental health status, and satisfaction with care.
[b] Adjusted for mental health status at the 12-month follow-up (time 0), demographic characteristics, insurance type, comorbidity score, mental health status, and satisfaction with care.

lated to the influence of income on the effect of cost sharing. Health Insurance Experiment subjects who were in the lowest income category suffered the worst health outcomes due to cost sharing. Others have also shown that the health of the poor is particularly sensitive to limitations in access to care.[11,28,29] Therefore, we may have failed to observe an association between cost sharing and worse health because subjects in the Medical Outcomes Study had relatively high incomes.

The sampling methods also might have weakened the relationship of cost sharing with health status. Because subjects were selected through physicians' offices, the study sample represents those who use care and probably overrepresents frequent users. Other studies have suggested that mortality rates are higher among those who forgo care because of poor access.[28,30] If so, those most affected by cost sharing might have been underrepresented in our sample.

The time frame of our analysis may not have been optimal to detect a negative impact on health outcomes. The RAND Health Insurance Experiment demonstrated that cost sharing had its greatest impact through lowering use of general health examinations and preventive care.[1] The effect on an individual's health of receiving less preventive care would probably be delayed. Thus, the 1-year follow-up in our analysis may have been too brief. In addition, we observed subjects after they had already been exposed to cost sharing for some time, and thus cost sharing may have already affected their health by the time of our study. Consequently, the study may have been biased owing to a survival effect.

A limitation of our study is that only 67% of the original cohort had sufficient follow-up data for inclusion in the analyses. Our sample was demographically different from the excluded sample and raises the possibility of sampling bias. Included subjects were more likely to have prepaid health plans, to be in better health, and to have answered the follow-up surveys. Thus, the excluded group may have been more vulnerable to cost sharing, which might partly explain why cost sharing appeared to have no effect on health status.

The present study was based on observational data; therefore, we cannot be completely assured of the comparability of the different cost-sharing groups, even after controlling for potential confounders. For example, a selection bias may exist given that those who are more likely to use medical care tend to choose more generous health plans.[31] The resulting endogenous relationship between cost sharing and use of medical care would tend to exaggerate an apparent effect of cost sharing on use of care without taking into account the effect of use of care on choice of health benefits. In addition, health insurance coverage differed among the 3 cost-sharing groups, raising the possibility that some unobserved differences in health plans confounded our results.

Another limitation was the use of self-reports to assess level of cost sharing, in that patients may be inaccurate in reporting details of their health benefits.[32] However, one might argue that perceived generosity of the health plan may be an equally or more important factor influencing use. Our cost-sharing measure also limited our ability to distinguish copayments from coinsurance. Copayments are generally considered to result in lower out-of-pocket expenditures, because the fee is fixed and not affected by the complexity of the service. This distinction may be important in measurements of the impact of cost sharing. Because of the sampling methods, our study underrepresented those who are younger, uninsured, and poor. Although our results lack generalizability to all patients in care, the present study complements previous work on this topic.[4,7]

The findings from our study may also not be generalizable to today's health care market, given the substantial changes that have taken place in the structure of managed care plans since the study was conducted, more than 10 years ago. Finally, incomplete follow-up data on deaths could have led to an underestimation of the effect of cost sharing on health. Seventy-seven individuals were lost to follow-up, possibly owing to death. However, these individuals were equally distributed among the 3 cost-sharing groups, which suggests that lack of follow-up death data did not bias our results.

Cost sharing clearly deters use of medical care, even among the chronically ill. Although patients seem able to distinguish between the necessity of care for less and more serious symptoms, we have shown that higher levels of cost sharing lead patients to seek care less often for serious symptoms, a finding that was not clearly demonstrated in the RAND Health Insurance Experiment. The results of this study also extend our understanding of cost sharing to an older, chronically ill population, a group previously receiving limited scrutiny.

Although we found no effect of cost sharing on health status, it is important to question its use, given that sufficiently high cost sharing appears to dissuade patients from

seeking care for serious symptoms, problems for which most physicians would agree that seeking care is appropriate. Because patients continue to cite costs as a significant barrier to care and out-of-pocket costs have recently been rising,[33–35] we need to remain vigilant of the extent to which cost sharing impedes patients' access to care and influences health outcomes. ■

About the Authors

Mitchell D. Wong, Ron D. Hays, and Martin F. Shapiro are with the Division of General Internal Medicine and Health Services Research, University of California, Los Angeles. Ron D. Hays and Martin F. Shapiro are also with RAND, Santa Monica, Calif. Ronald Andersen is with the Department of Health Services, School of Public Health, University of California, Los Angeles. Cathy D. Sherbourne is with RAND, Santa Monica, Calif.

Requests for reprints should be sent to Mitchell D. Wong, MD, PhD, Division of General Internal Medicine and Health Services Research, 911 Broxton Plaza, Los Angeles, CA 90095-1736 (e-mail: miwong@mednet.ucla.edu).

This article was accepted October 30, 2000.

Contributors

M.D. Wong planned and conducted all of the analyses and wrote the paper. R. Andersen, C.D. Sherbourne, R.D. Hays, and M.F. Shapiro provided guidance in designing the analysis and participated in the writing of the manuscript. M.F. Shapiro participated in the original design of some of the Medical Outcomes Study survey questions used for this analysis.

Acknowledgments

This research was supported by a Health Resources and Services Administration National Research Service Award to the Division of General Internal Medicine and Health Services, University of California, Los Angeles.

This paper was presented at the 22nd Annual National Meeting of the Society of General Internal Medicine, April 1999, San Francisco, Calif.

We wish to acknowledge John Ware and Sheldon Greenfield, leaders of the Medical Outcomes Study, for their cooperation in incorporating the variables reported here into the study data collection.

References

1. Lohr KN, Brook RH, Kamberg CJ, et al. Use of medical care in the RAND HIE: diagnosis- and service-specific analyses in a randomized controlled trial. *Med Care.* 1986;24(suppl):S1–S87.

2. Newhouse JP, Manning WG, Morris CN, et al. Some interim results from a controlled trial of cost sharing in health insurance. *N Engl J Med.* 1981;305: 1501–1507.

3. Keeler EB, Rolph JE. How cost sharing reduced medical spending of participants in the health insurance experiment. *JAMA.* 1983;249:2220–2222.

4. Shapiro MF, Ware JE Jr, Sherbourne CD. Effects of cost sharing on seeking care for serious and minor symptoms: results of a randomized controlled trial. *Ann Intern Med.* 1986;104:246–251.

5. Cherkin DC, Grothaus L, Wagner EH. The effect of office visit copayments on utilization in a health maintenance organization. *Med Care.* 1989;27: 669–679.

6. O'Grady KF, Manning WG, Newhouse JP, Brook RH. The impact of cost sharing on emergency department use. *N Engl J Med.* 1985;313:484–490.

7. Shapiro MF, Hayward RA, Freeman HE, Sudman S, Corey CR. Out-of-pocket payments and use of care for serious and minor symptoms: results of a national survey. *Arch Intern Med.* 1989;149:1645–1648.

8. Rasell ME. Cost sharing in health insurance: a reexamination. *N Engl J Med.* 1995;332:1164–1168.

9. Selby JV. Cost sharing in the emergency department. *N Engl J Med.* 1997;336:1750–1751.

10. Brook RH, Ware JE Jr, Rogers WH, et al. Does free care improve adults' health? *N Engl J Med.* 1983; 309:1426–1434.

11. Lurie N, Kamberg CJ, Brook RH, Keeler EB, Newhouse JP. How free care improved vision in the Health Insurance Experiment. *Am J Public Health.* 1989;79: 640–642.

12. Tarlov AR, Ware JE, Greenfield S, Nelson EC, Perrin E, Zubkoff M. The Medical Outcomes Study: an application of methods for monitoring the results of medical care. *JAMA.* 1989;262:925–930.

13. Stewart AL, Ware JE Jr. *Measuring Functioning and Well-Being: The Medical Outcomes Study Approach.* Durham, NC: Duke University Press; 1992.

14. Ware JE Jr, Kosinski M, Keller SK. *SF-36 Physical and Mental Health Summary Scales: A User's Manual.* Boston, Mass: Health Institute, New England Medical Center; 1994.

15. Baker DW, Shapiro MF, Schur C, Freeman H. A revised measure of symptom-specific health care use. *Soc Sci Med.* 1998;47:1609–1610.

16. Marshall GN, Hays RD, Sherbourne CD, Wells KB. The structure of patient ratings of outpatient medical care. *Psychol Assess.* 1993;5:477–483.

17. Rubin HR, Gandek B, Rogers WH, Kosinski M, McHorney CA, Ware JE Jr. Patients' ratings of outpatient visits in different practice settings: results from the Medical Outcomes Study. *JAMA.* 1993;270:825–840.

18. Mantel N. Chi-square tests with one degree of freedom: extensions of the Mantel-Haenszel procedure. *J Am Stat Assoc.* 1963;58:690–700.

19. Neter J, Kutner MH, Nactsheim CJ, Wasserman W. *Analysis of Covariance in Applied Linear Statistical Models.* 4th ed. Boston, Mass: WCB McGraw-Hill; 1996: 1010–1034.

20. Kravitz RL, Greenfield S, Roger W, et al. Differences in the mix of patients among medical specialties and systems of care—results from the Medical Outcomes Study. *JAMA.* 1992;267:1617–1623.

21. Neter J, Kutner MH, Nactsheim CJ, Wasserman W. *Building the Regression Model II: Diagnostics in Applied Linear Statistical Models.* 4th ed. Boston, Mass: WCB McGraw-Hill; 1996:261–292.

22. Cook RD, Weisberg S. *Residuals and Influence in Regression.* New York, NY: Chapman & Hall; 1982.

23. *SAS/STAT User's Guide, Version 6.* 4th ed, vol 2. Cary, NC: SAS Institute Inc; 1989.

24. Davis K. Equal treatment and unequal benefits: the Medicare program. *Milbank Q.* 1975;53:449–488.

25. Link CR, Long SH, Settle RF. Cost sharing, supplementary insurance, and health services utilization among the Medicare elderly. *Health Care Financing Rev.* 1980;2(2):25–31.

26. Reeder CE, Nelson AA. The differential impact of copayment on drug use in a Medicaid population. *Inquiry.* 1985;22:396–403.

27. Magid DJ, Koepsell TD, Every NR, et al. Absence of association between insurance copayments and delays in seeking medical care among patients with myocardial infarction. *N Engl J Med.* 1997;336:1722–1729.

28. Lurie N, Ward NB, Shapiro MF, Brook RH. Termination from Medi-Cal—does it affect health? *N Engl J Med.* 1984;311:480–484.

29. Lurie N, Ward NB, Shapiro MF, Gallego C, Vaghaiwalla R, Brook RH. Termination of Medi-Cal benefits. A follow-up study one year later. *N Engl J Med.* 1986;314:1266–1268.

30. Franks P, Clancy CM, Gold MR. Health insurance and mortality: evidence from a national cohort. *JAMA.* 1993;270:737–741.

31. Vistnes JP, Banthin JS. The demand for Medicare supplemental insurance benefits: the role of attitudes toward medical care and risk. *Inquiry.* 1997–1998;34: 311–324.

32. Nelson DE, Thompson BL, Davenport NJ, Penaloza LJ. What people really know about their health insurance: a comparison of information obtained from individuals and their insurers. *Am J Public Health.* 2000;90: 924–928.

33. Sullivan CB, Miller M, Feldman R, Dowd B. Employer-sponsored health insurance in 1991. *Health Aff.* 1992;11:172–185.

34. Gabel J, DiCarlo S, Sullivan C, Rice T. Employer-sponsored health insurance, 1989. *Health Aff.* 1990;9: 161–175.

35. Gabel J. Ten ways HMOs have changed during the 1990s. *Health Aff.* 1997;16:134–145.

Kirsten Koch

From: Brannen, Tyler <Tyler.J.Brannen@ins.nh.gov>
Sent: Wednesday, February 10, 2021 10:43 AM
To: Tom Sherman
Cc: Jeb Bradley; James Gray; Becky Whitley; Kevin Avard; Kirsten Koch
Subject: NYT COVID Testing Article

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Senator Sherman,

Here is one of the articles I was thinking of, from November 10th: https://www.nytimes.com/2020/11/10/upshot/covid-testing-doctor-fees.html?searchResultPosition=42.

Another that discusses the risk of added fees: https://www.nytimes.com/2020/11/13/upshot/coronavirus-surprise-bills-guide.html?searchResultPosition=58.

A ProPublica article: https://www.propublica.org/article/how-a-covid-19-test-led-to-charges#:~:text=Insurance%20representatives%20told%20ProPublica%20that,19%20treatment%2C%20insurance%20representatives%20said..

Also, it occurred to me after testifying that patients might face cost sharing for other services during the visit that a COVID test is administered. The patient may not realize the distinction.

Tyler Brannen
Director of Health Economics
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
603-271-2396
New email: tyler.j.brannen@ins.nh.gov

Insurance is complex. We are here to help.
Contact our Consumer Services Division with questions or complaints at (800) 852-3416 or consumerservices@ins.nh.gov
https://www.nh.gov/insurance
Like us on Facebook: www.facebook.com/NHInsuranceDepartment
Follow us on Twitter: @NHInsuranceDept

Voting Sheets

Senate Health and Human Services Committee
EXECUTIVE SESSION RECORD
2021-2022 Session

Bill # SB 123

Hearing Date: 2/10/21

Executive Session Date: 3/3/21

Motion: Amendment #2021-0414s **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard	X			X	
Sen. Sherman	X	X		X	
Sen. Whitley	X		X	X	

Motion: OTPA **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard	X			X	
Sen. Sherman	X	X		X	
Sen. Whitley	X		X	X	

Motion: Consent Calendar **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X	X		X	
Sen. Avard	X		X	X	
Sen. Sherman	X			X	
Sen. Whitley	X			X	

Motion: _____ **Vote:** _____

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Reported out by: Sen. Sherman

Notes: _____

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE
FOR THE CONSENT CALENDAR

Thursday, March 4, 2021

THE COMMITTEE ON Health and Human Services

to which was referred **SB 123**

AN ACT relative to copayments for COVID-19 testing.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 5-0

AMENDMENT # 0621s

Senator Tom Sherman
For the Committee

This bill, as amended, establishes that it is unlawful for any employer, as defined in RSA 275:4, to require any employee or applicant for employment to pay the cost of a COVID-19 test as a condition of employment. This bill protects employees and applicants by ensuring that they will not have to pay for a COVID-19 testing required by their employer.

Kirsten Koch 271-3266

FOR THE CONSENT CALENDAR

HEALTH AND HUMAN SERVICES

SB 123, relative to copayments for COVID-19 testing.
Ought to Pass with Amendment, Vote 5-0.
Senator Tom Sherman for the committee.

This bill, as amended, establishes that it is unlawful for any employer, as defined in RSA 275:4, to require any employee or applicant for employment to pay the cost of a COVID-19 test as a condition of employment. This bill protects employees and applicants by ensuring that they will not have to pay for a COVID-19 testing required by their employer.

Docket of sb123		
01/29/2021	S	Introduced 01/06/2021 and Referred to Health and Human Services; SJ 3
02/05/2021	S	Remote Hearing: 02/10/2021, 09:00 am; Links to join the hearing can be found in the Senate Calendar; SC 10
03/04/2021	S	Committee Report: Ought to Pass with Amendment # 2021-0621s, 03/11/2021; Vote 5-0; CC; SC 14
03/11/2021	S	Committee Amendment # 2021-0621s, RC 23Y-1N, AA; 03/11/2021; SJ 7
03/11/2021	S	Ought to Pass with Amendment 2021-0621s, RC 23Y-1N, MA; OT3rdg; 03/11/2021; SJ 7
03/17/2021	H	Introduced (in recess of) 02/25/2021 and referred to Labor, Industrial and Rehabilitative Services HJ 4 P. 50
05/05/2021	H	Public Hearing: 05/05/2021 02:00 pm Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/91070566113 / Executive session on pending legislation may be held throughout the day (time permitting) from the time the committee is initially convened.
05/26/2021	H	Executive Session: 05/26/2021 10:00 am Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/99484571505
05/27/2021	H	Majority Committee Report: Ought to Pass with Amendment # 2021-1758h (Vote 11-9; RC) HC 26 P. 27
05/27/2021	H	Minority Committee Report: Inexpedient to Legislate
06/04/2021	H	Lay on Table (Rep. Infantine): MA DV 355-10 06/04/2021

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB 123 **Senate Committee:** HHS

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee

X All Calendar Notices

X Hearing Sign-up sheet(s)

X Prepared testimony, presentations, & other submissions handed in at the public hearing

X Hearing Report

___ Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

___ - amendment # _____ X - amendment # 2021-0414s Prentiss/Sherman

___ - amendment # _____ X - amendment # 2021-0621s

X Executive Session Sheet

X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment # _____ ___ - amendment # _____

___ - amendment # _____ ___ - amendment # _____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):

___ Enrolled Bill Amendment(s)

___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

X as amended by the senate ___ as amended by the house

___ final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Kirsten Koch 7/26/21

Committee Aide **Date**

Senate Clerk's Office AK