A Home Health Co-Payment: Affected Beneficiaries and Potential Impacts

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Avalere Health LLC

Executive Summary

78 percent of home health users who are not dual eligibles do not have Medigap coverage and could have to pay the full co-payment out of pocket*

- Nearly 52 percent of these home health users have *incomes below 200% of the poverty line*
- The co-payment for three episodes would consume almost *6 percent of annual income* for a beneficiary at 150 percent of the federal poverty line, living alone

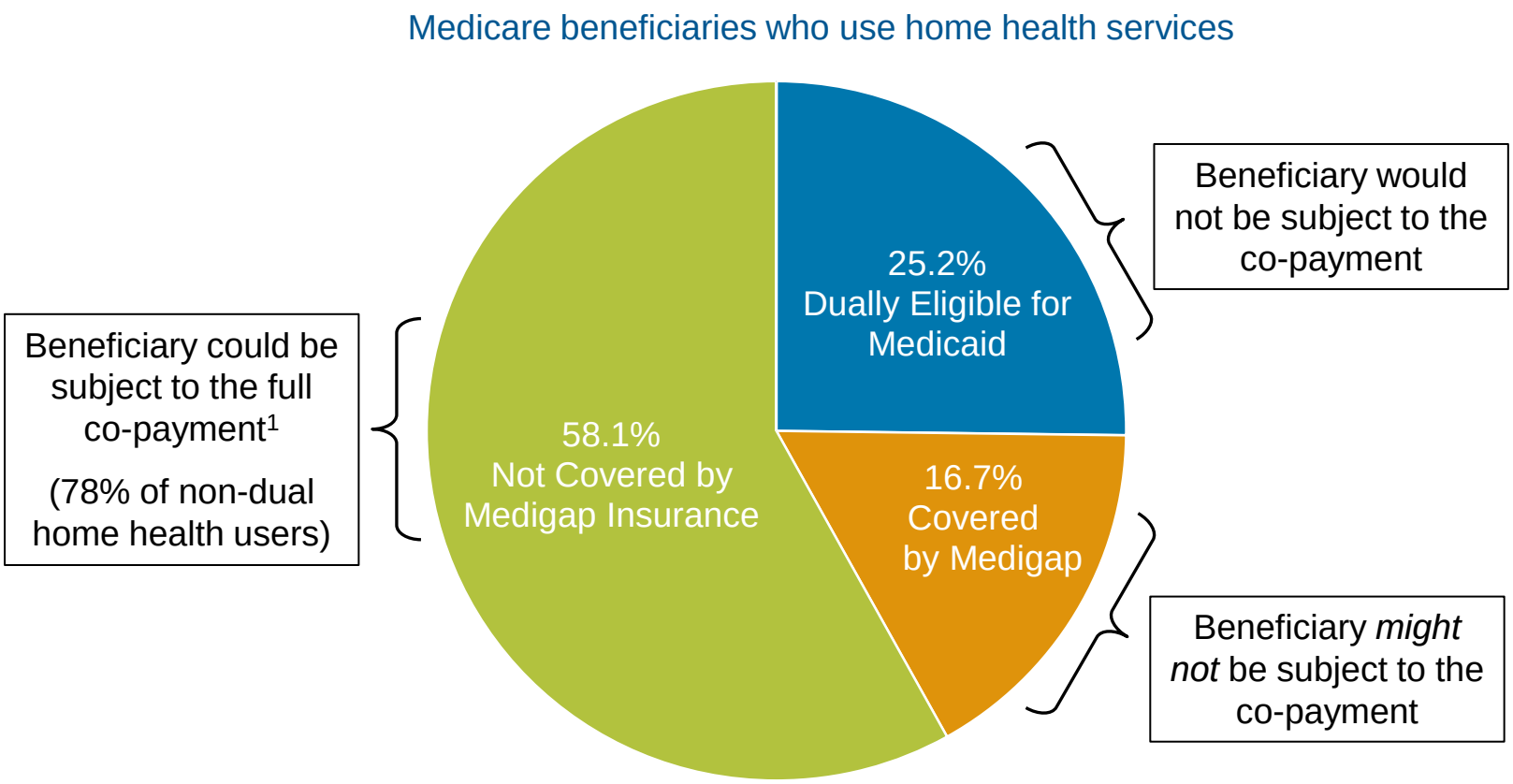
Home health users without Medigap coverage are sicker, more likely to have severe disabilities, and more likely to live alone than other Medicare beneficiaries

- 86 percent of home health users who would pay the co-payment out of pocket have *3 or more chronic conditions*; 36 percent live alone
- 19 percent have disabilities severe enough to quality for a nursing home level of care

Studies show that co-payment policies that reduce utilization of services (such as outpatient visits) can lead to higher inpatient costs.[1]

*Some of these beneficiaries may have other private health insurance that could cover a home health co-payment.
[1]Trivedi, Amal N., Husein Moloo and Vincent Mor. "Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly." *New England Journal of Medicine* 362 (2010): 320-328.

Home Health Users in 2008



Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.
[1]Some of these beneficiaries may have other private insurance coverage that could cover a home health co-payment.

Potential Impact of Proposed Home Health Co-Payment

The co-payment could constitute a significant financial burden

- For purposes of this analysis, we assume a co-payment of $300 per episode
- In this scenario, the co-payment for three episodes would represent 6 percent of annual income for a beneficiary at 150 percent of the poverty line, living alone
- Almost 52 percent of (non-dual eligible) home health users without Medigap coverage have incomes under 200 percent of the Federal Poverty Level

The co-payment proposal will affect a vulnerable population

- Home health users are sicker, more likely to have a disability, and more likely to live alone than other Medicare beneficiaries.
- Studies suggest that the negative effects of cost-sharing disproportionately affect poorer, sicker beneficiaries

A home health co-payment could lead to unintended effects

- In some states, the proposed co-payment could shift costs from Medicare to Medicaid
- Imposing cost-sharing for this population could lead to higher utilization of inpatient services, meaning increased costs for Medicare[1]

[1]Trivedi, Amal N., Husein Moloo and Vincent Mor. "Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly." *New England Journal of Medicine* 362 (2010): 320-328.

Potential Financial Impacts of a Home Health Co-Payment

Co-Payments Could Constitute a Financial Burden for Low-Income Beneficiaries

- 78 percent of home health users who are not dual eligibles do not have Medigap coverage, and could have to pay the full co-payment out of pocket*
- This group of home health users is predominantly lower-income – 52 percent are below 200 percent of the Federal Poverty Line (FPL), compared to 41 percent of all Medicare beneficiaries[1]
- The co-payment for three episodes would consume almost 6 percent of annual income for a beneficiary at 150 percent of the FPL, living alone
- Studies suggest that low-income beneficiaries often perceive co-payments to be a significant financial burden[2]

*Some of these beneficiaries may have other private insurance that could cover a home health co-payment.
[1]Dual eligibles are excluded from both groups.
[2]Ku, Leighton, Elaine Deschamps and Judi Hilman. "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program." Center on Budget and Policy Priorities, November 2004.

Three or More Episodes Would Represent 3-14 Percent of Annual Income for Low-Income Beneficiaries – Comparable to Spending on Transportation or Food[1]

Number of Home Health Episodes	Living Arrange-ment	Co-Pay as Percent of Household Income at 100 Percent FPL	Co-Pay as Percent of Household Income at 150 Percent FPL	Co-Pay as Percent of Household Income at 200 Percent FPL
One Episode	Alone	2.8%	1.8%	1.4%
	2-person	2.0%	1.4%	1.0%
Two Episodes	Alone	5.5%	3.7%	2.8%
	2-person	4.1%	2.7%	2.0%
Three Episodes	Alone	8.3%	5.5%	4.1%
	2-person	6.1%	4.1%	3.1%
Five Episodes	Alone	13.8%	9.2%	6.9%
	2-person	10.2%	6.8%	5.1%

Note: These data were calculated as a percentage of the 2011 Federal Poverty Level for a household of one or two ($10,890 and $14,710, respectively), assuming a $300 per episode co-payment.

[1]Individuals under 65 years old devoted 4.1 percent of annual expenditures to car payments and 12.8 percent to food. Consumer Expenditures in 2008. Bureau of Labor Statistics. U.S. Department of Labor. March 2010.

Home Health Co-Payments Likely to Affect Low-Income, Sicker Medicare Home Health Beneficiaries

Many low-income beneficiaries are not enrolled in programs that may cover the co-payment, and even those with Medigap may not be protected

Medicaid	Medicare Savings Programs	Medigap
More than half of eligible, community-dwelling beneficiaries are not enrolled.[1] These beneficiaries are the poorest and least likely to be able to afford a co-payment	One-third of eligible Medicare beneficiaries are not enrolled in the Qualified Medicare Beneficiary (QMB) program, which covers Medicare cost-sharing requirements[2]	Only 22 percent of home health users have coverage. Some existing Medigap plans do not cover co-payments; the extent to which these co-payments would be covered is unclear

The remaining 78 percent of these non-dual eligible home health users could be subject to the full co-payment; these beneficiaries are disproportionately low-income, in poor health, and living alone, putting them at risk of health decline

If beneficiaries with low income and/or in poor health forgo needed care, *both adverse health events and inpatient costs could increase*

[1] Pezzin, Lilianna E. and Judith D. Kapser. "Medicaid Enrollment among Elderly Medicare Beneficiaries: Individual Determinants, Effects of State Policy, and Impact on Service Use." *Health Services Research* 37(4) (2002).
[2] Haber, Susan G., Walter Adamache, Edith G. Walsh, Sonja Hoover and Anupa Bir. "Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs." RTI, 2003.

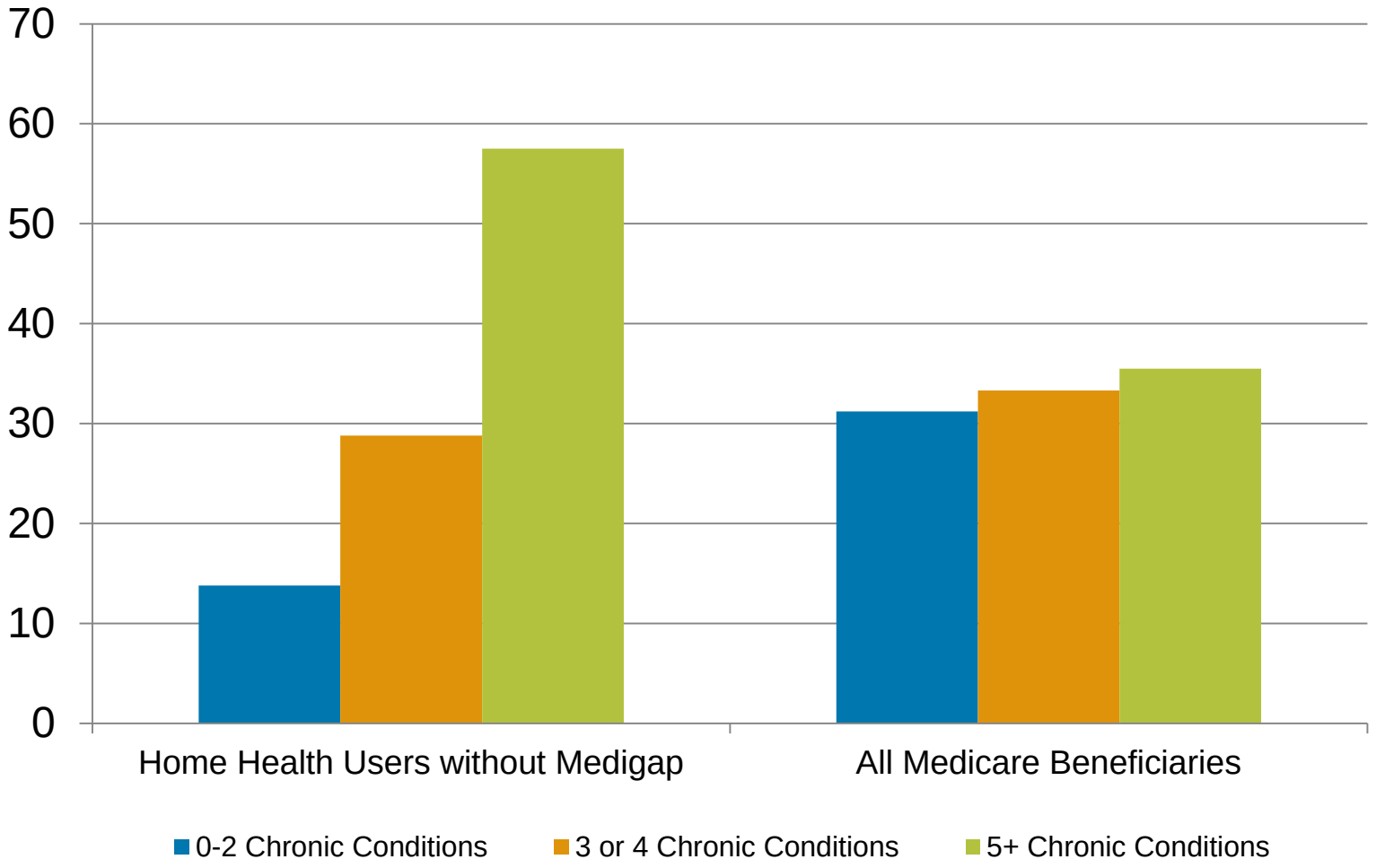
Profile of Home Health Users Who Would be Subject to the Co-Payment

Home Health Users without Medigap Are Older and in Poorer Health than Other Medicare Beneficiaries

	Home Health Users without Medigap	All Medicare Beneficiaries
Over age 85	28.1%	11.7%
Live alone	36.4%	31.8%
Have 3 or more chronic conditions	86.2%	68.6%
Have 2 or more Activities of Daily Living limitations[1]	18.8%	5.8%
Report fair or poor health	45.9%	26.7%
Are in somewhat or much worse health than last year	40.7%	23.1%

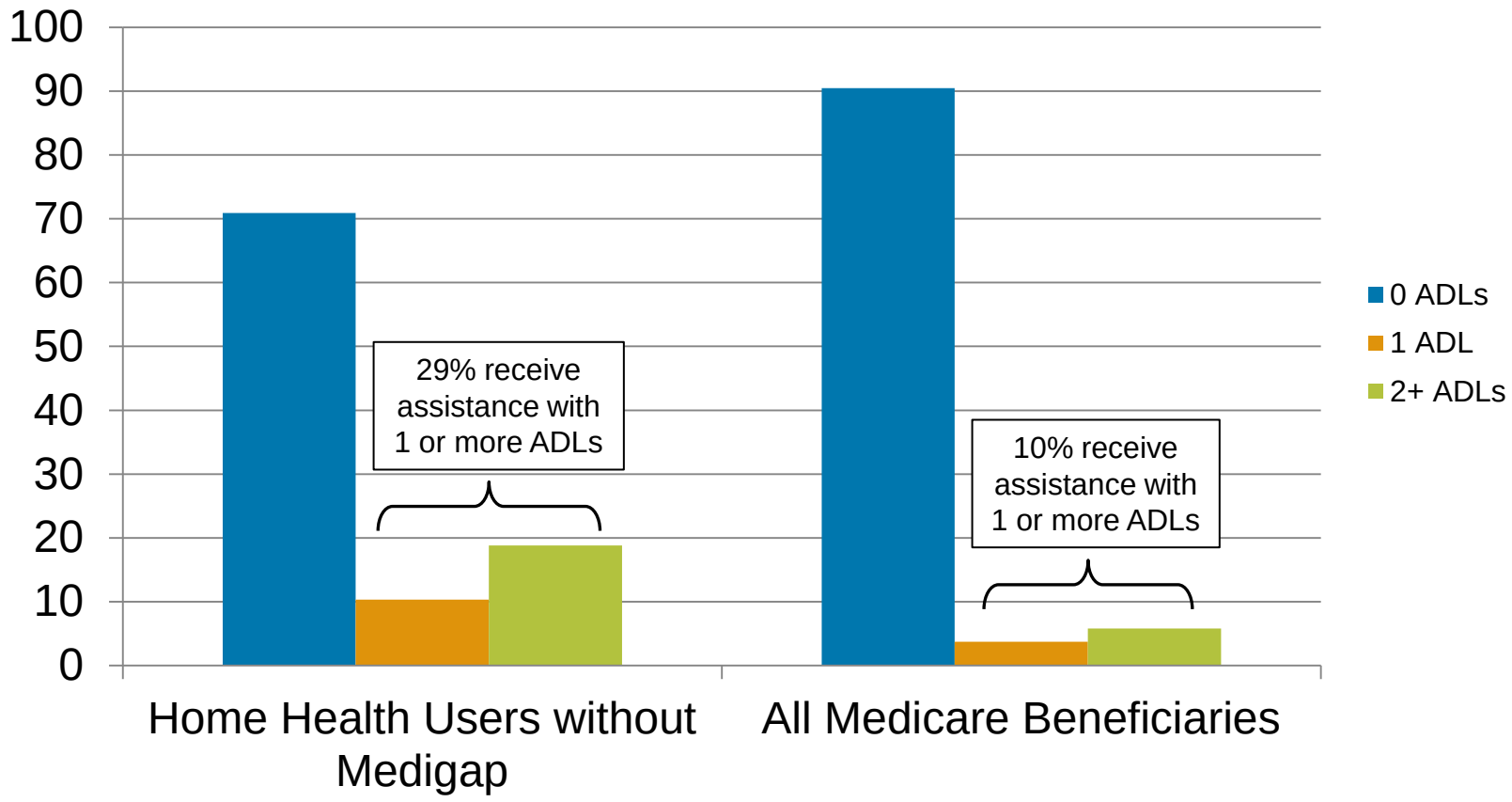
Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.
[1]This is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.

Home Health Users without Medigap Are More Likely to Have Five or More Chronic Conditions



Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.

Home Health Users without Medigap Are More Likely to Have Moderate to Severe Disability



Note: In most states, people requiring assistance with 2 or more Activities of Daily Living (bathing, dressing, transferring, using the toilet, eating, and continence) are considered to have an "institutional level of need", meaning they are sufficiently disabled as to potentially need placement in a nursing home or to need other paid long-term care services.[1]

Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.
[1]Kaye, Stephen, Charlene Harrington and Mitchell P. LaPlante. "Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much?" Health Affairs 29(1) (2010): 11-21.

Home Health Users without Medigap Have High Utilization of Other Medicare Services, Despite Cost-Sharing Requirements

	Beneficiary Cost-Sharing Requirement[1]	Annual Average for Home Health Users without Medigap	Annual Average for All Medicare Beneficiaries
Physician claims	20 percent of the Medicare-approved amount	52.5 claims	21.9 claims
Office visits	Same as above	11.6 visits	6.5 visits
DME claims	Same as above	5.9 claims	1.9 claims
Inpatient days	$1,132 deductible for days 1–60	8.6 days	1.4 days
SNF days	$0 for first 20 days, $141.50 per day for days 21–100	7.3 days	0.7 days

Consistent with their poorer health, home health users without Medigap have higher utilization of all Medicare services, which suggests that their home health usage is not driven primarily by the absence of a co-payment; *imposing a home health co-payment may not reduce utilization to the extent expected*

Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.
[1]All beneficiaries are subject to a deductible of $162 for Part B-covered services or items.

Research on the Effects of Co-Payments

Studies Suggest That Co-Payments for Some Services Can Lead to Increased Utilization of More Expensive Services

Trivedi *et al.,* in *The New England Journal of Medicine*, analyzed a nationally representative sample of elderly Medicare managed care enrollees[1] and found that:

Decreases

Medicare Advantage plans that raised co-payments for outpatient care had 19.8 *fewer annual outpatient visits* per 100 enrollees, however…

Increases

These plans saw 2.2 *more annual hospital admissions* and 13.4 *more inpatient days* per 100 enrollees

The authors estimate that the *cost of the additional hospitalizations exceeded the savings* from the decrease in outpatient visits

[1]Trivedi, Amal N., Husein Moloo and Vincent Mor. "Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly." *New England Journal of Medicine* 362 (2010): 320-328.

Adverse Effects of Co-Payments Are Greater for People with Chronic Disease and/or Low Incomes

A study on the impact of co-payments in Utah's Medicaid program found that *individuals in poor health* suffered adverse effects, especially if they were low income[1]

- Between 2001 and 2002, Utah instituted co-payments for most services. Co-pays were modest: $2 per physician/outpatient hospital visit or prescription
- Nevertheless, 39 percent of beneficiaries stated that the *co-payments caused serious financial difficulties*

Chandra *et al.,* found that when California's public retirement system raised drug and office co-payments:[1]

- For beneficiaries with the greatest chronic disease comorbidities (Charlson Index 4 or more), increased inpatient *costs exceeded savings* from decreased physician and drug use by 78 percent

If beneficiaries with low income and/or in poor health forgo needed care, *both adverse health events and inpatient costs could increase*

[1]Ku, Leighton, Elaine Deschamps and Judi Hilman. "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program." Center on Budget and Policy Priorities, November 2004.

Data Specifications

Avalere's Analysis of Home Health Beneficiaries

The data in this presentation were generated using the 2008 Medicare Current Beneficiary Survey (MCBS) Access to Care file, which includes the "always enrolled" Medicare population, or beneficiaries who were enrolled for the full calendar year[1]

To create a demographic profile of home health users who would be subject to a co-payment, we excluded:

- Dual-eligible beneficiaries
- Beneficiaries residing in a facility, such as a nursing home
- Beneficiaries reporting that they are enrolled in a Medigap plan

Some Medigap plans do not fully cover co-payments. On the other hand, some of the beneficiaries who are not enrolled in a Medigap plan may have other private health insurance (e.g., retiree health coverage) that could potentially cover a home health co-payment.

[1]Beneficiaries who died after the fall survey are included in this file.
[2]MCBS also includes two income categories for beneficiaries who are unsure of their income: "less than $25,000" and "more than $25,000." We included these beneficiaries to the extent that they fell into one of our income categories.