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

May 21, 2013

Avalere Health LLC

Executive Summary

38 percent of Medicare home health beneficiaries who are not dual eligibles do not have supplemental insurance coverage and would likely have to pay the full co-payment out of pocket

» 73% percent of these home health users have *incomes below 200% of the poverty line*

Medicare home health beneficiaries without supplemental insurance coverage are sicker and more likely to have severe disabilities than other Medicare beneficiaries

» 86 percent of these home health users who would pay the co-payment out of pocket have *3 or more chronic conditions*

» 29 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]

[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.

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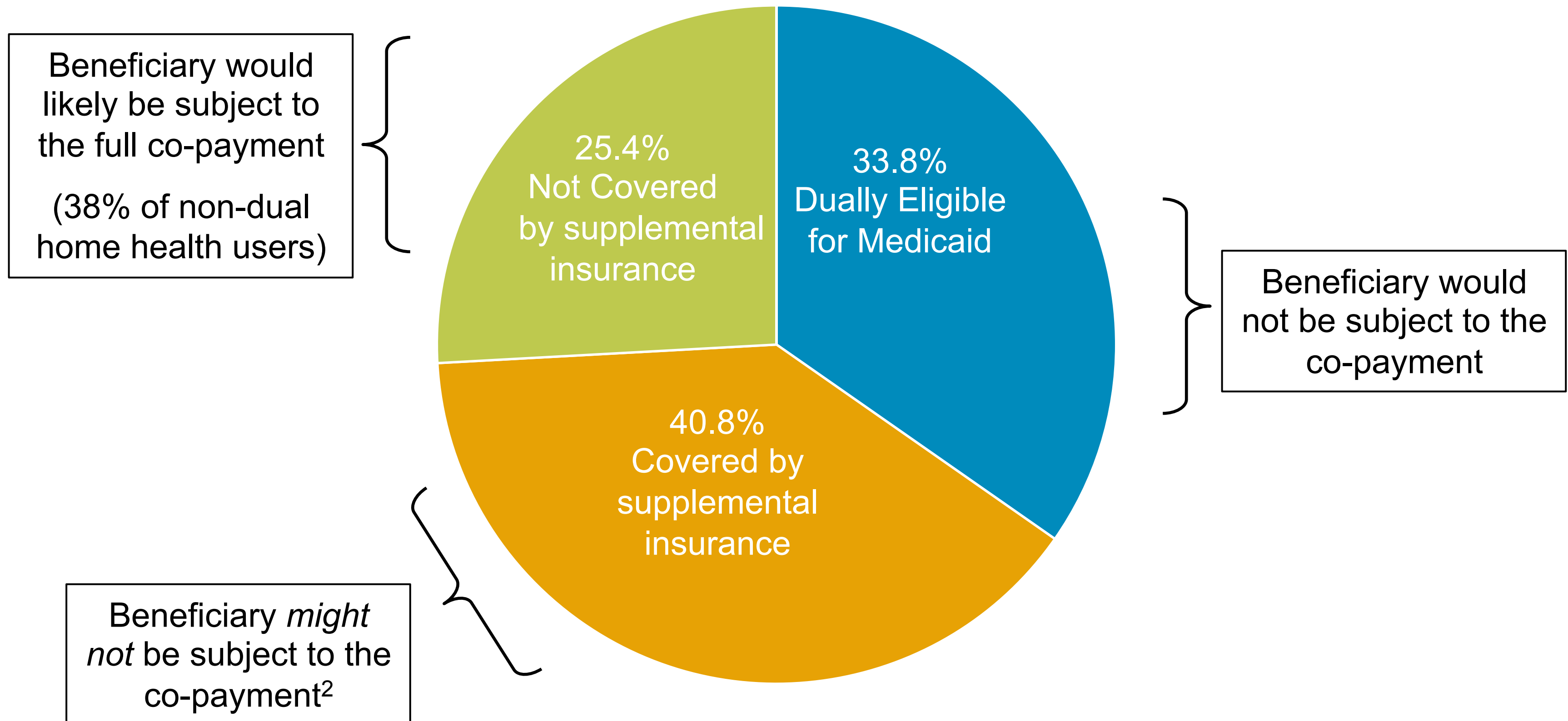
Medicare Home Health Beneficiaries[1] (2011)



Source: Avalere Health analysis of 2011 Medicare Current Beneficiary Survey, Access to Care file.
[1]Part B home health users defined as individuals with Part B reimbursement; excludes many but not all Part A users.
[2]Depending on whether the supplemental coverage is comprehensive and would cover a new co-payment

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Potential Impact of Proposed Home Health Co-Payment

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

The co-payment could constitute a significant financial burden

» Almost 73 percent of (non-dual eligible) home health users without supplemental insurance coverage have incomes under 200 percent of the Federal Poverty Level

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.

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Profile of Medicare Home Health Beneficiaries Who Would Likely Be Subject to the Co-Payment

Home Health Beneficiaries without Supplemental Coverage Are Older and in Poorer Health than Other Beneficiaries

	Medicare Home Health Beneficiaries	All Medicare Beneficiaries
Income below 200% FPL	73.0%	38.0%
Over age 85	25.5%	11.8%
Have 3+ chronic conditions	86.0%	69.8%
Have 2 or more Activities of Daily Living limitations[1]	29.1%	4.8%
Report fair or poor health	46.7%	21.4%
Are in somewhat or much worse health than last year	42.2%	21.0%

Source: Avalere Health analysis of 2011 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

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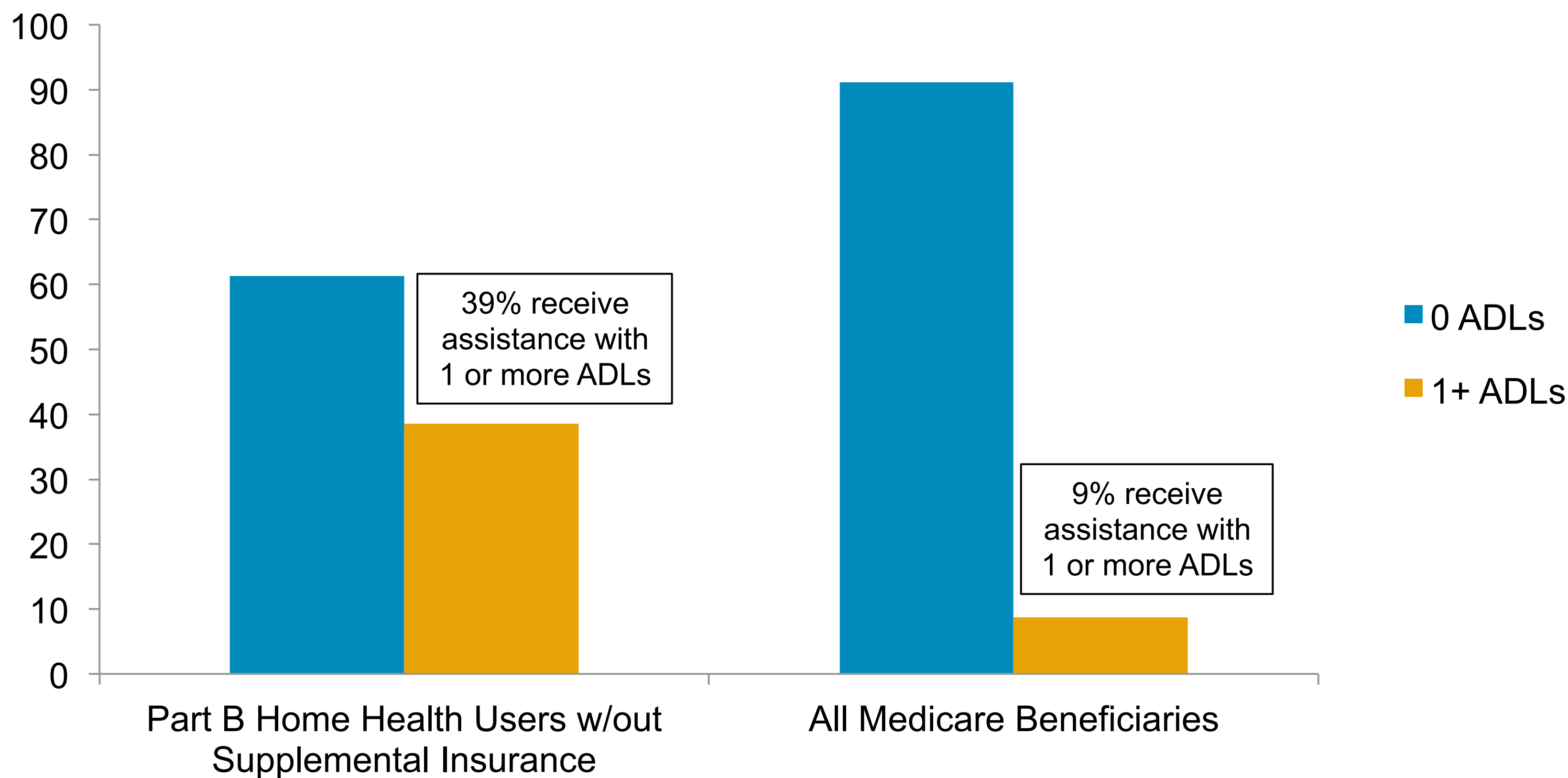
Home Health Beneficiaries without Supplemental Insurance Are More Likely to Have Moderate to Severe Disability



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 other paid long-term care services.[1]

Source: Avalere Health analysis of 2011 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.

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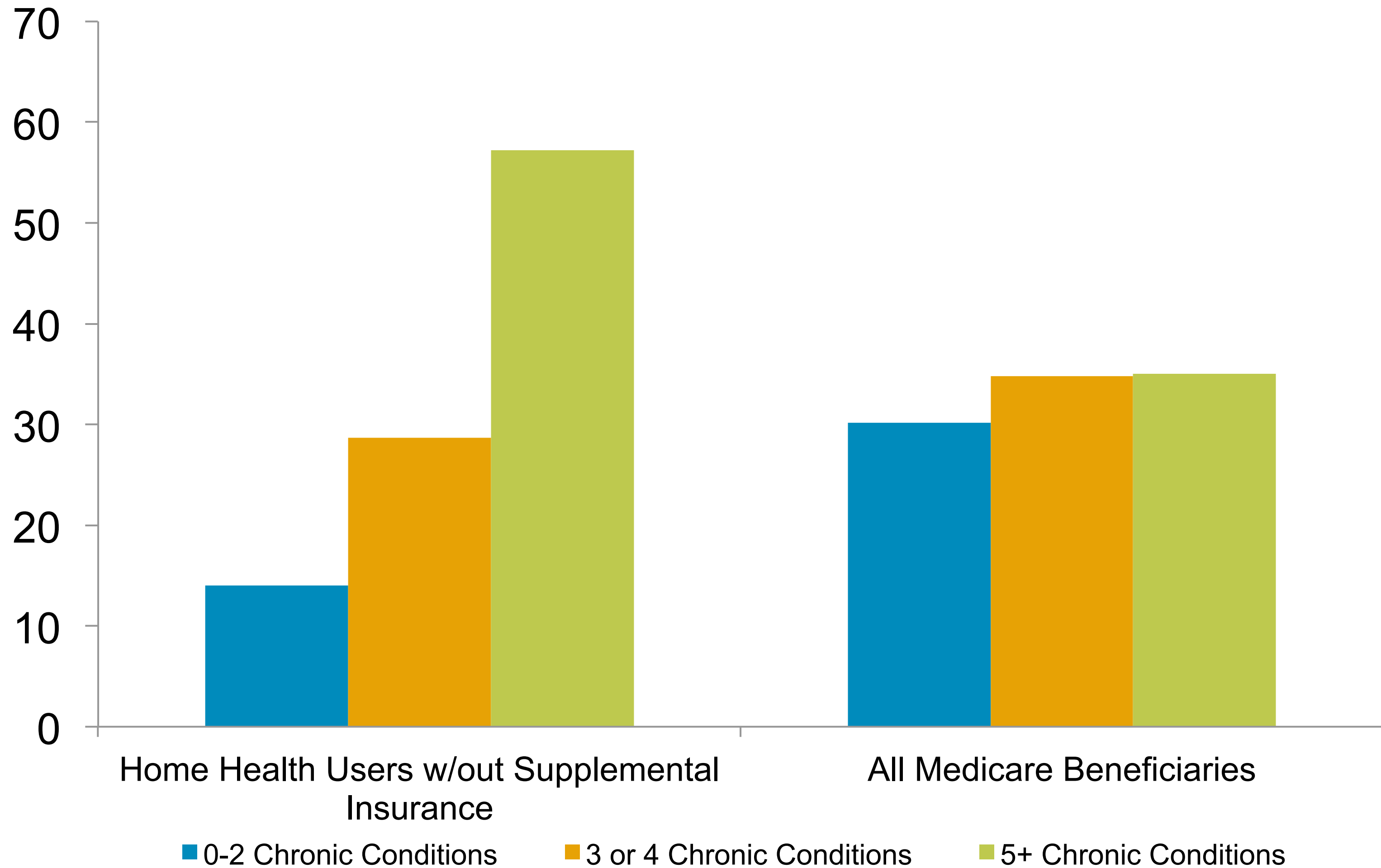
Home Health Beneficiaries without Supplemental Coverage Are More Likely to Have 5+ Chronic Conditions



Source: Avalere Health analysis of 2011 Medicare Current Beneficiary Survey, Access to Care file.

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Potential Financial Implications of a Home Health Co-Payment

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

Thirty-eight percent of Medicare home health beneficiaries who are not dual eligibles do not have supplemental insurance coverage and would likely have to pay the full co-payment out of pocket

This group of beneficiaries is predominately lower-income:

- 73 percent of Medicare home health beneficiaries are below 200 percent of the Federal Poverty Line (FPL)
- By contrast, 38 percent of all Medicare beneficiaries are below 200 percent of the Federal Poverty Line (FPL)[1]

Studies suggest that low-income beneficiaries often perceive co-payments to be a significant financial burden[2]

[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.

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Many Home Health Beneficiaries Lack Co-Payment Coverage

Many low-income beneficiaries are not enrolled in programs that would cover the co-payment, and even those with supplemental insurance might not be protected

Medicaid	Medicare Savings Programs	Supplemental Insurance
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]	In some cases supplemental coverage is limited to particular services such as dental care; even broader employer-sponsored insurance might not cover a new home health co-payment.

The non-dual eligible home health users without supplemental coverage would likely 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.

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Co-Payments Could Lead to Higher Treatment Costs

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.

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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.

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Data Specifications

Avalere's Analysis of Medicare Home Health Beneficiaries

The data in this presentation were generated using the 2011 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 limited our analysis to Part B home health users

We excluded:

- » Medicare Advantage Enrollees
- » Dual-eligible beneficiaries
- » Beneficiaries residing in a facility, such as a nursing home
- » Beneficiaries reporting that they are enrolled in a supplemental insurance plan

As discussed above, some supplemental insurance plans are limited to particular services or otherwise would not cover a new 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.

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