

**COMMITTEE ON WAYS AND MEANS  
SUBCOMMITTEE ON HEALTH**

Hearing on the President's and Other Bipartisan Proposals to Reform Medicare

May 21, 2013

Chairman Brady, Ranking Member McDermott, and distinguished Members of the House Ways and Means Subcommittee on Health, on behalf of the Partnership for Quality Home Healthcare ("Partnership"), I would like to thank you for the Committee's commitment to strengthening the Medicare program and for this opportunity to offer the following points and testimony:

- **The Partnership urges Congress to exercise caution in changing Medicare cost sharing rules and believes that the re-imposition of costs on clinically and financially vulnerable Medicare home health beneficiaries should be avoided in favor targeted program integrity reforms;**
- **Medicare home health beneficiaries are older, poorer and sicker than average beneficiaries and are less likely to have supplemental insurance, making them more vulnerable to directly bearing the costs associated with home health copayment and uniform cost sharing policies;**
- **Both a home health copayment and uniform cost sharing structure run the risk of dislocating seniors from their homes into higher-cost institutional settings, creating hardship for seniors and their families, for State Medicaid programs, and for taxpayers; and**
- **The Partnership urges Congress to review and consider the factors that led Congress to repealing the home health copayment in 1972, including the financial burden it imposed on seniors and the dislocation of many of them to more costly institutional settings.**

**EXECUTIVE SUMMARY**

The Partnership is a coalition of skilled home healthcare providers who are dedicated to developing innovative reforms to improve the program integrity, quality, and efficiency of the Medicare home health benefit. The Partnership believes any proposal that would re-impose out of pocket costs on Medicare home health beneficiaries is of concern and that savings should instead be achieved by enacting targeted program integrity reforms that effectively address the isolated instances of aberrant behavior that have occurred in the Medicare home health benefit.

Our concerns relate to proposals that would specifically impact seniors' access to home health care, as well as to broader proposals affecting the full scope of Medicare benefits, such as uniform cost sharing. The re-imposition of a home health copayment poses many risks to beneficiaries, providers and taxpayers alike, and the establishment of uniform cost sharing without adequate protections could

compel low-income seniors to fund as much as half the cost of home health episodes occurring early in the year. In brief, we are concerned that these changes would expose seniors to unsustainable out of pocket costs and lead to the dislocation of seniors from care in their homes to more costly settings.

For these reasons, the Partnership is concerned that proposals to re-impose a home health copay or establish uniform cost-sharing without adequate protections: (1) are problematic to the disproportionately poor Medicare beneficiaries who are homebound, who already have significant financial resources of their own at stake when it comes to the cost of their health care, and who would have difficulty absorbing new financial obligations; (2) are likely to once again cause seniors who today receive clinically advanced treatment in their homes to instead obtain that care in higher cost institutional settings; and (3) should be given very careful consideration in light of Congress' repeal of the home health copayment in 1972.

In order to fully assess this issue, the Partnership commissioned Avalere Health to determine the anticipated impact of the re-imposition of a home health copayment. We hope this analysis, which is discussed more fully below, will be of value to the Committee.

In sum, the Partnership urges the Subcommittee not to re-impose out of pocket costs on Medicare home health beneficiaries and to instead authorize targeted program integrity reforms that have already been proven effective in curtailing fraud and abuse. The Partnership believes such a targeted approach constitutes a fairer and more effective policy solution than the across-the-board re-imposition of out of pocket costs on all seniors nationwide. By delivering substantial savings and preventing further losses to fraud and abuse without harming senior citizens or the vast majority of providers who are honest and compliant, we respectfully submit that targeted program integrity reform would be in the best interest of seniors, caregivers, and taxpayers.

## DISCUSSION

### I. Demographic and Impact Analysis of a Home Health Copayment

In light of the findings of the Avalere Health analysis detailed below, the Partnership is concerned about the re-imposition of out of pocket costs on homebound Medicare beneficiaries, especially since these seniors are disproportionately older, poorer, and sicker than the Medicare beneficiary population as a whole.<sup>1</sup>

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<sup>1</sup> The data used to assemble this submission come from Avalere Health's Analysis of Home Health Beneficiaries. The data 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.<sup>1</sup> To create a demographic profile of home health users who would be subject to a copayment, Avalere limited its analysis to home health users. Avalere excluded: Medicare Advantage Enrollees, Dual-eligible beneficiaries, beneficiaries residing in a facility, such as a nursing home, and beneficiaries reporting that they are enrolled in a supplemental insurance plan. As noted above, some supplemental insurance plans are limited to particular services or otherwise would not cover a home health co-pay.

A. Impact: Seniors’ Clinical Complexity

Assuming a \$150 per episode copayment, Avalere found that thirty eight percent of home health users who are not dual eligibles do not have supplemental insurance coverage and would therefore likely have to pay the full co-payment out of pocket. Seventy three percent of these home health users have incomes below 200% of the poverty line.

Not only are these individuals financially vulnerable to copays, they are sicker and more likely to be disabled than other Medicare beneficiaries. Eighty six percent of home health users who would pay the co-payment out of pocket have three or more chronic conditions, and twenty nine percent have disabilities severe enough to qualify for a nursing home level of care.

Per the table below, Medicare home health beneficiaries without supplemental insurance are older and in poorer health than the Medicare beneficiary population as a whole:

	Medicare Home Health Beneficiaries	All Medicare Beneficiaries
Over Age 85	25.5%	11.8%
3 or More Chronic Conditions	86.0%	69.8%
2 or more ADL Limitations	29.1%	4.8%
Requiring ADL Assistance	39.0%	9.0%

Indeed, Medicare home health beneficiaries without supplemental insurance are more likely to have five or more chronic conditions. Of home health users without supplemental insurance, about 15 percent have between 0 and 2 chronic conditions, just under 30 percent have 3 or 4 chronic conditions, and about 58 percent have 5 or more chronic conditions – whereas, of all Medicare beneficiaries, about 30 percent have between 0 and 2 chronic conditions, about 35 percent have 3 or 4 chronic conditions, and about 35 percent have 5 or more chronic conditions.

These seniors are also more likely to have a disability. Of all home health beneficiaries without supplemental insurance, nearly 40 percent require assistance with one or more Activity of Daily Living (ADL), such as bathing, dressing, transferring, using the toilet, eating, and continence. By contrast, fewer than 10 percent of all Medicare beneficiaries receive any ADL assistance.

As the Committee knows, people requiring assistance with two or more ADLs are considered in most states to have an “institutional level of need,” meaning they are sufficiently disabled as to potentially need placement in a nursing home or other long-term care facility.<sup>2</sup> In light of these data, the services needed by Medicare home health beneficiaries is commonly recognized as due to their generally significantly poorer health rather the lack of a co-payment.

B. Impact: Seniors’ Financial Vulnerability

<sup>2</sup> 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.

Assuming a \$150 per episode copayment, Avalere Health found that thirty eight percent of home health users 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 home health users is predominantly lower-income – 73 percent are below 200 percent of the Federal Poverty Line (FPL), compared to 38 percent of all Medicare beneficiaries (dual eligibles are excluded from both groups).

New cost sharing obligations for home health care use would therefore consume a significant share of the annual income for a beneficiary at 150 percent of the FPL, after accounting for living expenses and premiums.

Consistent with these findings, other studies suggest that low-income beneficiaries often perceive co-payments to be a significant financial burden.<sup>3 4</sup>

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. In Medicaid, for example, more than half of eligible community-dwelling beneficiaries are not enrolled.<sup>5</sup> In Medicare, one third of eligible Medicare beneficiaries are not enrolled in the Qualified Medicare Beneficiary (QMB) program, which covers Medicare cost-sharing requirements.<sup>6</sup>

Also, because the Medicaid home health benefit differs from Medicare's skilled home health benefit, it is unlikely that states, facing financial pressures nationwide, will coordinate with a new Medicare cost sharing requirement and pay their share of this new cost, which could even further restrict seniors' access to services.

As Governors, including Governor Martin O'Malley (D-MD) and Governor Nathan Deal (R-GA) have pointed out, if patients cannot afford home health care because of a new copayment, those patients may need to stay in the hospital or nursing home, settings that cost far more than his or her home and which makes an individual who does not need to be there susceptible to additional complications. Furthermore, the result would impose significant new dollars in additional Medicaid costs onto states for such institutional care.

Even for those with supplemental insurance, 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

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<sup>3</sup> 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.

<sup>4</sup> Individuals over 65 years old devote 4.1 percent of annual expenditures to car payments and 3 percent to apparel. *Consumer Expenditures in 2011*. BUREAU OF LABOR STATISTICS. U.S. DEPARTMENT OF LABOR. April 2013.

<sup>5</sup> Pezzin, Lilianna E. and Judith D. Kasper. *Medicaid Enrollment among Elderly Medicare Beneficiaries: Individual Determinants, Effects of State Policy, and Impact on Services Use*. HEALTH SERVICES RESEARCH 37(4)(2002)

<sup>6</sup> 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.

income and/or in poor health forgo needed care, both adverse health events and inpatient costs would increase.

Finally and just as importantly, these seniors already have significant financial resources of their own at stake in their health care, since they personally bear costs like housing, utilities, food, and laundry that taxpayers would bear if the seniors received treatment in facilities rather than in their own home.

### C. Impact: Higher System Costs

Additionally, re-institution of repealed co-payments may result in higher costs to the system. Studies show that co-payment policies that reduce utilization of services (such as outpatient visits) can lead to higher inpatient costs.<sup>7</sup> Trivedi et al., in *The New England Journal of Medicine*, analyzed a nationally representative sample of elderly Medicare managed care enrollees<sup>8</sup> and found that Medicare Advantage plans that raised co-payments for outpatient care had 19.8 fewer annual outpatient visits per 100 enrollees. However, those plans saw 2.2 more annual hospital admissions and 13.4 more inpatient days per 100 enrollees. Importantly, the authors estimate that the total cost of the additional hospitalizations exceeded the savings from the decrease in outpatient visits.

Research also shows that the adverse effects of co-payments are greater for people with chronic disease and/or low incomes. For example, a study of 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.<sup>9</sup> Between 2001 and 2002, Utah instituted co-payments for most services. Co-payments were modest: \$2 per physician/outpatient hospital visit or prescription. Nevertheless, 39 percent of beneficiaries stated that the co-payments caused serious financial difficulties.

Similarly, an analysis of California's public retirement system found that when drug and office co-payments were raised, beneficiaries with the greatest chronic disease comorbidities (Charlson Index 4 or more) experienced increased inpatient costs, which exceeded savings from decreased physician and drug use by 78 percent.<sup>10</sup> If beneficiaries with low income and/or in poor health forgo needed care, both adverse health events and inpatient costs could increase

Finally, in their analysis of the President's copayment proposal, former CBO Director Douglas Holtz Eakin and health economist Robert Book wrote: "One might think the goal is to save tax dollars by replacing government spending with patient spending. But that's not the case, as the average spending in a home health episode is \$3,000, so the co-payment would represent only about 3 percent of total spending....In other words, the President's budget doesn't target the 3 percent that would become the patient's copayment; it's targeting the 97 percent that won't be spent if patients can't, or won't, come up with the copayment." The authors also concluded that a new copayment may result in

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<sup>7</sup> 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.

<sup>8</sup> *Id.*

<sup>9</sup> *See supra* note 3.

<sup>10</sup> *Id.*

the deterioration of patients' clinical conditions, causing many of them to "end up requiring hospital care to fix a problem that could have been prevented in the first place."<sup>11</sup>

## II. Home Health Copayments Were Tried – and Repealed

The Medicare home health benefit originally included a 20 percent copayment to seniors who accessed it. In 1972, Congress passed an amendment repealing coinsurance payments for home health services citing copayments as a "financial burden to many elderly patients living on marginal incomes." Congress also recognized the inefficiencies associated with copayments for home health services, which often caused patients to forgo physician prescribed home health to avoid costs and instead wound up receiving care in more expensive institutional settings.

The cost of providing skilled home health services was then – and remains now – significantly lower than treatment provided in traditional care settings. For instance, the average Medicare payment for a hospital stay of a few days is \$10,000. By contrast, a typical home health episode, which spans 60 days, costs approximately \$3,000.

For all the same reasons that drove Congress to eliminate the home health copayment in 1972 – including its financial burden on seniors and the adverse cost consequences that resulted when care shifted to more expensive settings – Congress should avoid re-instituting a policy that was affirmatively repealed.

## III. A Better Alternative: Program Integrity Reform

If one goal of a copayment is to curb utilization in Medicare's home health benefit and/or reduce instances of fraud and abuse in the sector, re-imposing an out of pocket cost on innocent seniors would seem to be a poor solution. Instead, we urge Congress to instead pass targeted reforms that would strengthen the integrity of the Medicare program.

We note that such an approach has already been proven effective in curtailing fraud and abuse: Since 2010, CMS has been using a payment safeguard that the home health community proposed to prevent payment of aberrant outlier claims. This single reform is already on track to save more than \$11 billion over the next decade – all without harming innocent seniors or the vast majority of providers who are honest and compliant.

Similar safeguards can be built to prevent payment of aberrant excessive and low-utilization payment adjustment (LUPA), which would prove similarly targeted and effective. Our preliminary scoring estimates suggest that these two payment safeguards can generate more than \$15 billion over

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<sup>11</sup> Robert A. Book and Douglas Holtz-Eakin, *Home Health Medicare Co-Pay: A Study In Unintended Consequences*, FORBES (April 19, 2013) available at <http://www.forbes.com/sites/aroy/2013/04/19/home-health-medicare-co-pay-a-study-in-unintended-consequences/>

10 years, far surpassing the \$700 million in savings projected in the President's budget for the re-institution of the repealed home health copayment.

## CONCLUSION

For all the reasons stated above, the Partnership urges the Committee not to resurrect the failed and repealed copayment policy. Furthermore, it urges the Committee to not to establish uniform cost sharing that impose new costs on already economically and clinically compromised seniors. Instead, the Partnership believes targeted program integrity reform constitutes a fairer and more effective policy solution than the across-the-board re-imposition of out of pocket costs on all seniors nationwide.

By delivering substantial savings and preventing further losses to fraud and abuse without harming innocent senior citizens or the vast majority of providers who are honest and compliant, we respectfully submit that targeted program integrity reform would be in the best interest of seniors, caregivers, and taxpayers.

Respectfully Submitted,



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