Note

The Price of Reform: Cost-Sharing Proposals for the Medicare Home Health Benefit

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Faced with an impending Medicare "crisis," scholars and policymakers have advanced a variety of proposals for reforming the program. This Note critically examines one proposed solution that draws on an established technique of health policy and insurance—beneficiary cost-sharing—to reduce expenditures in the rapidly-growing Medicare home health program. Recognizing that cost-sharing mechanisms might generate some savings, the author ultimately rejects these proposed remedies in light of their inequitable consequences and practical limitations.

This Note proceeds by establishing a normative framework for assessing cost-sharing proposals. The author then evaluates the normative implications of an array of cost-sharing mechanisms, taking into account the unique demographic and usage characteristics of the beneficiary population. Drawing on empirical research into the effects of cost-sharing on such variables as income and health status, this Note explores the demand response of beneficiaries. The author concludes that cost-sharing likely would be either ineffective or inequitable. In contrast, alternative reform proposals are likely to generate cost-savings without the normative limitations of beneficiary cost-sharing. This Note urges the abandonment of attempts to extend cost-sharing to the home health benefit, and calls for a further exploration of alternative methods to assume the program's long-term solvency.

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Faced with consistent increases in program spending and even higher future costs, the Medicare program is undeniably at a cross-roads. Total Medicare expenditures grew by a yearly average of 8.5% between 1990 and 1996,1 and demographic projections regarding the “aging” of the U.S.

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The Price of Reform

population have led many to predict much higher future outlays and an impending “Medicare crisis.” Among the many possible areas for reform, Medicare funding for home health care has proven a particularly attractive candidate. In recent years, post-acute services, which include home health care, skilled nursing facilities (SNF), and hospice programs, have been the fastest growing components of Medicare. Average annual growth of expenditure per enrollee in these programs between 1990 and 1996 was 27.9%, 23.2%, and 33.1%, respectively. Furthermore, total Medicare spending on home health care has grown—in the words of one critic—“exponentially,” rising from $2.5 billion in 1989 to $16.8 billion in 1996. In addition to these cost increases, widespread allegations of fraud and abuse by home health agencies (HHAs) have lent impetus to reform proposals.

The congressional and administrative response to these developments has been swift and far-reaching. The passage of the Balanced Budget Act of 1997 (BBA) responded to the dramatic increase in home health reimbursement costs by calling for the introduction of a prospective payment system (PPS) for the home health program by October 1, 1999. Spending, measured in real terms, has been slightly lower. See MEDPAC DATA BOOK, supra, at 8 ch.1-7.

2 Under one model, the Brookings-ICF-Long-Term Care Financing Model, the number of persons over 65 years of age is projected to grow from 32.7 million in 1993 to 49.2 million in 2018, a 50% increase in 25 years. See JOSHUA M. WIENER ET AL., SHARING THE BURDEN: STRATEGIES FOR PUBLIC AND PRIVATE LONG-TERM CARE INSURANCE 36-37 (1994). In light of such projections, the notion of an impending “Medicare crisis” has permeated public and scholarly discourse. See, e.g., Tom Curry, Rethinking Medicare, MSNBC (visited Mar. 1, 1999) <http://www.msnbc.com/news/136650.asp> (discussing an impending “Medicare crisis”).

3 Commonly referred to as a “nursing home,” the SNF is defined under the Medicare statute as “an institution . . . which (1) is primarily engaged in providing to residents (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases.” 42 U.S.C.A. § 1395f-3(a) (West Supp. 1999).

4 Under the Medicare statute, “hospice care” encompasses an array of services to the terminally ill. Covered services include nursing care, physical or occupational therapy, medical social services, home health aides services, medical supplies, physician services, and short-term inpatient care. See 42 U.S.C. § 1395x(dd)(1) (1994).

5 MEDICARE PROFILE, supra note 1 at 25.

6 See id., at 34 fig.22.

7 H. Gilbert Welch et al., The Use of Medicare Home Health Care Services, 335 NEW ENG. J. MED. 324, 324 (1996).


10 See Balanced Budget Act § 4603 (codified as amended at 42 U.S.C.A. § 1395fff (West Supp. 1999)). A PPS operates by setting payment rates in advance of the actual provision of medical services to patients. In theory, providers have an incentive to reduce costs under the PPS; assuming their costs are below the PPS payment rates, they can pocket the difference. The PPS for the Medicare home health benefit is to be designed to achieve an overall reduction in provider expenditures equivalent to a 15% reduction in the cost limits and per beneficiary limits put in place under the
During the transition to this PPS, the BBA instituted an Interim Payment System (IPS) to control reimbursement costs, while initiating more stringent eligibility requirements and other guidelines.\footnote{11}

In addition, numerous anti-fraud initiatives have been introduced. Operation Restore Trust, a joint federal-state initiative, exposed very high rates of HHA noncompliance with Medicare’s coverage criteria, putting those providers who engaged in fraudulent practices on notice for their misconduct.\footnote{12} Furthermore, the passage of the Health Insurance Portability and Accountability Act (HIPAA)\footnote{13} in 1996 initiated a strengthening of the existing Medicare/Medicaid Anti-Kickback Law\footnote{14} by instituting a general crack-down on health-care fraud and by creating new categories of federal crimes for health care providers.\footnote{15} In addition, the BBA itself created new civil penalties for violations of the Anti-Kickback Law, while strengthening other existing penalties.\footnote{16} Moreover, the Office of the Inspector General (OIG) for the Department of Health and Human

\footnote{11} Whereas HHAs previously were paid their actual costs up to a cap based on 112% of the national average cost per visit, adjusted for local wage levels and each agency’s mix and number of visits, the BBA decreased this cap to 105% of the national median per visit cost. See Balanced Budget Act § 4602 (a)(5) (codified as amended at 42 U.S.C.A. § 1395x(v)(I)(L)(i) (West Supp. 1999)). The BBA also added an annual average per beneficiary limit to the calculation of the payment cap. This per beneficiary limit is based on the average payment for home health services for each beneficiary receiving care during an agency’s fiscal year ending before October 1, 1994. Agencies participating a full year before this date (“established” agencies) faced limits based 75% on 98% of the “reasonable costs” for the agency’s 12-month cost-reporting period, and 25% on 98% of the regional average per beneficiary payment for the same period. See id. § 4602(c) (codified as amended at 42 U.S.C.A. § 1395x(v)(I)(L)(v) (West Supp. 1999)). An agency that had not participated in Medicare for a full year by October 1994 is considered “new,” and faces a per beneficiary limit based on the national median of the per beneficiary limits for established agencies. See id.; see also GAO, GAO/HEHS-98-238, MEDICARE HOME HEALTH BENEFIT: IMPACT OF INTERIM PAYMENT SYSTEM AND AGENCY CLOSURES ON ACCESS TO SERVICES $ (1998) [hereinafter IMPACT OF INTERIM PAYMENT].

\footnote{12} In 1995, the Office of the Inspector General (OIG) put the home health industry on notice regarding fraudulent and abusive practices. See OIG Special Fraud Alert, 60 Fed. Reg. 40,847 (Dep’t Health and Human Serv. 1995).


\footnote{14} 42 U.S.C. § 1320a-7(b) (1994); see also Balanced Budget Act § 4331 (strengthening HIPAA provisions).


\footnote{16} Balanced Budget Act of 1997 § 4331(d) (codified as amended in relevant part at 42 U.S.C.A. § 1320a-7e (West Supp. 1999)). The BBA also introduced a surety bond requirement to deter further fraudulent practices. See id. § 4312(b) (codified as amended at 42 U.S.C.A. § 1395x(a) (West Supp. 1999)).
Services (HHS) has called for enhanced disclosure by health-care providers, and has set forth measures by which home health suppliers can police themselves while devoting more time to the education of staff and contractors regarding the compliance demands of Medicare and Medicaid regulations.\footnote{As part of “Operation Restore Trust,” the OIG has initiated a voluntary self-disclosure protocol for health care providers. See OIG Provider Self-Disclosure Protocol, 63 Fed. Reg. 58,399 (Dep’t Health and Human Serv. 1998). The OIG further outlined a Compliance Program Guidance for Home Health Agencies, detailing compliance measures—including education of staff and contractors—that HHAs are encouraged to adopt to guard against fraud. See OIG Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410 (Dep’t Health and Human Serv. 1998).} Finally, regulatory measures enacted by the Health Care Financing Administration (HCFA) following the BBA may have been effective in stemming fraud and abuse.\footnote{HCFA placed a moratorium on certification of any new home health agencies for the six months following September 15, 1997. Moreover, HCFA also now requires agencies to reapply every three years for continued certification and has increased both the number of audits of HHAs and the number of claims reviews conducted by the government. See HARRIET L. KOMISAR & JUDITH FEDER, THE COMMONWEALTH FUND, THE BALANCED BUDGET ACT OF 1997: EFFECTS ON MEDICARE’S HOME HEALTH BENEFIT AND BENEFICIARIES WHO NEED LONG-TERM CARE 12-13 (1998); Amy Goldstein, President Acts To Curb Home Health Care Fraud, WASH. POST, Sept. 16, 1997, at A4.}

These anti-fraud measures, in tandem with the rigid IPS criteria, already seem to have mitigated growth in Medicare home health costs and in the number of HHA openings.\footnote{Between 1995 and 1996, growth had already begun to slow, with Medicare home health outlays rising only 8%. The number of HHAs participating in Medicare grew 33.3% between October 1, 1994 (7920) and October 1, 1997 (10,557). However, the number of participating HHAs operating in August 1, 1998 was only 9842—a 6.8% decrease. See IMPACT OF INTERIM PAYMENT, supra note 11, app. IV, at 24-25. While recognizing the possible role of both Operation Restore Trust measures and IPS payment limitations in the recent downturn, a GAO official noted other possible factors, including the “increased use of managed care and the maturation of the home health industry.” GAO, GAO/T-HEHS-98-234, MEDICARE: INTERIM PAYMENT SYSTEM FOR HOME HEALTH AGENCIES 5 (1998).} Indeed, these measures have led a significant number of HHAs to end their Medicare participation,\footnote{The GAO found 554 HHA “voluntary closures” and 206 “involuntary closures” (i.e., situations in which agencies were no longer permitted to bill Medicare because of failure to meet program requirements) nationwide between October 1997 and July 1998. See IMPACT OF INTERIM PAYMENT, supra note 11, at 3. This figure is significantly below initial industry calculations for the same period, which (erroneously) had indicated 2704 closures. See B. Schorr, Has IPS Killed 2,704 HHAs? Study by 2 HHA Exec Included Branches, Pre-IPS Closings, HOME HEALTH LINE, Feb. 22, 1999, at 3-4.} incurring the wrath of the home health industry\footnote{The National Association for Home Care (NAHC) engaged in intense lobbying efforts to repeal IPS provisions perceived to be adverse to the industry. See, e.g., US Senate Members Press for IPS Reform, NAHC REP. 780 (Sept. 25, 1998) <http://www.nahc.org/tango/report>. The NAHC also has filed suit against HCFA, attempting to invalidate as “arbitrary and capricious” agency regulations interpreting the IPS reimbursement limitations. See NAHC IPS Lawsuit Advances, NAHC REP. 795 (Jan. 29, 1999) <http://www.nahc.org/tango/report>.} and prompting Congress to moderate some of the more draconian IPS requirements.\footnote{Industry efforts to obtain relief bore fruit in the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999, Pub. L. No. 105-277, 112 Stat. 2681 (codified as amended at 42 U.S.C.A. § 1395 (West Supp. 1999)). The Act allowed HHAs whose FY 1998 limits were below the national median to set FY 1999 limits at one-third the difference between the 1998 limits and the national median. See Appropriations Act § 5101(a)(3) (codified as amended at 42 U.S.C.A. § 1395x(v)(1)(L) (West Supp. 1999)). The Act also set the per beneficiary limits for “new” agencies at the national median.} Given the
difficulties associated with making HCFA's systems Y2K compliant and the numerous problems encountered by HCFA in formulating the home-health PPS, Congress also extended the deadline for PPS implementation to October 2000. This delay led some to speculate that the IPS might remain in place for additional years, prompting concern as to how the system should be managed to constrain costs more effectively.

Cost control through beneficiary cost-sharing has been proposed by both the Medicare Payment Advisory Commission (MedPAC) and its predecessor, the Prospective Payment Assessment Commission (ProPAC). Legislative initiatives to impose beneficiary copayments on home health services have been repeatedly (and unsuccessfully) attempted over the years. However, the BBA contemplates the possible introduction of beneficiary cost-sharing, with the median of the per beneficiary limits based on 100% of costs, rather than 98%. In addition, the Act established limits for agencies certified on or after October 1, 1998 at 75% of the limits for "new" agencies as defined in the BBA. See id. The Act also increased the per visit limits to 106% of the median cost per visit for cost reporting periods beginning in FY 1999. See id. § 5101(b)(3) (codified at 42 U.S.C.A. § 1395x(v)(1)(L)(iv) (West Supp. 1999)); see also MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 92 & nn.8-9 (1999) [hereinafter 1999 MEDPAC REPORT].

See Appropriations Act § 5101(c)(1)-(2) (codified as amended at 42 U.S.C.A. § 1395ff (West Supp. 1999)). MedPAC has noted the difficulties experienced thus far in attempting to design a home-health PPS, remarking that "it has been difficult to design a PPS that appropriately classified patients who require both short and longer-term home health services." 1999 MEDPAC REPORT, supra note 22, at 92. Efforts to render HCFA operations Y2K compliant also contributed to the delay in PPS implementation. See Telephone Interview with Karen Beebe, Health Care Financing Administration (Feb. 26, 1999).

The decision to roll back the PPS deadline also effectively circumvented the BBA "contingency" provision, see supra note 7. The Appropriations Act pushed back the effective date for this contingency provision to September 30, 2000. See Appropriations Act § 5101(c)(3) (codified as amended at 42 U.S.C.A. § 1395ff (West Supp. 1999)).

Telephone Interview with Michael Kinslow, National Association for Home Care (Feb. 18, 1999). However, HHS Secretary Donna Shalala recently assured Congress that the PPS would be in place by October 1, 2000. See Shalala Reports Progress on PPS for Home Care, NAHC REP. (Jan. 2, 1999) <http://www.nahc.org/tango/report> [hereinafter Shalala Reports].

Established under the BBA, MedPAC is an independent federal body charged with advising Congress on issues affecting the Medicare program. MedPAC was formed out of two previous organizations, the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC). See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4022, 111 Stat. 251, 350-55 (codified as amended at 42 U.S.C.A. 1395b(6) (West Supp. 1999)).

26 See, e.g., American Health Security Act of 1999, H.R. 1200, 106th Cong. § 201(b)(2) (1999) (applying a 20% coinsurance, subject to exemption or reduction for low-income beneficiaries, to home and community-based long-term care services offered under a proposed state-based universal health insurance program); Balanced Budget Act of 1997, H.R. 2015, 105th Cong. § 5362(a) (requiring a $5 copayment per visit for Medicare Part B home health services, subject to an annual out-of-pocket maximum equal to the inpatient hospital deductible); S. 947, 105th Cong. § 5362(a) (1997) (same); Restructuring a Limited Government Act, H.R. 1923, 104th Cong. § 12,001 (1995) (imposing a
of beneficiary copayments if actual Medicare home health outlays exceed estimates for each fiscal year between 1999 and 2002. MedPAC argues that cost-sharing would force beneficiaries to assess more critically their home health service needs and might help to police fraud by encouraging beneficiaries to review the number and type of services billed. MedPAC also notes that Medicare home health care and clinical laboratory services are the "only major Medicare benefits that currently require no cost-sharing."  

This Note analyzes the merits and disadvantages of beneficiary cost-sharing as a means of curbing expenditures in the Medicare home health program. I first establish a theoretical framework for gauging the normative acceptability of cost-sharing, premised in part on considerations of vertical equity. I conclude that beneficiary cost-sharing is an excessively blunt instrument for achieving cost reductions. Cost-sharing is likely to deter both medically-necessary and -unnecessary home health usage. Moreover, cost-sharing unreasonably burdens the most vulnerable segment of the Medicare population. Although cost-sharing might conceivably be structured to mitigate this burden, the fiscal savings achievable through such "watered-down" cost-sharing are not worth the costs. Finally, I argue that alternative means of reducing home health expenditures—including measures already in place—should be more than sufficient to reduce home health care growth to more politically acceptable

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27 The BBA reads in pertinent part: Not later than the end of each of years 1999 through 2002, the Secretary shall submit to [various congressional committees] a report that compares the actual outlays under such parts for such services during the fiscal year ending the year, to the outlays estimated . . . for such fiscal year. If the Secretary finds that such actual outlays were greater than such estimated outlays for the fiscal year, the Secretary shall include in the report recommendations regarding beneficiary copayments for home health services provided under the medicare [sic] program or such other methods as will reduce the growth in outlays for home health services under the medicare [sic] program.


28 See 1999 MedPAC REPORT, supra note 22, at 94.

29 Id.
levels.

While many scholars have examined critically the use of cost-sharing in public health insurance programs, including Medicare, no systematic attempt to assess the implications of cost-sharing for Medicare home health has yet been undertaken. The NAHC has opposed the use of copayments and other such techniques in home health care, while MedPAC has consistently supported cost-sharing, however, neither proponents nor detractors of the cost-sharing idea have engaged in a systematic inquiry into its probable consequences. Indeed, no "natural" or "true" experiments have been conducted regarding the use of beneficiary cost-sharing in home health care, making any projections regarding the effects of cost-sharing inevitably somewhat speculative. This Note draws on existing studies of the effects of cost-sharing in analogous health care domains and attempts to gauge the likely impact of cost-sharing on cost,

30 See, e.g., GREG L. STODDART ET AL., PREMIER'S COUNCIL ON HEALTH, WELL-BEING AND SOC. JUSTICE, USER CHARGES, SNARES AND DELUSIONS: ANOTHER LOOK AT THE LITERATURE (Ont., Can. 1994) (arguing that user charges are detrimental to the achievement of a number of vital policy objectives); Douglas Conrad & Theodore R. Marmor, Patient Cost-Sharing, in THEODORE R. MARMOR, POLITICAL ANALYSIS AND AMERICAN MEDICAL CARE 207 (1983) (examining the appropriate uses and limits of patient cost-sharing); Robert G. Evans & Morris L. Barer, User Fees for Health Care: Why a Bad Idea Keeps Coming Back (Or, What's Health Got to Do With It?), 14 CANADIAN J. AGING 360 (1995) (arguing that user fees benefit the healthy and wealthy, while hurting the aged and vulnerable); Thomas Rice & Kathleen R. Morrison, Patient Cost Sharing for Medical Services: A Review of the Literature and Implications for Health Care Reform, 51 MED. CARE REV. 235 (1994) (assessing the benefits and disadvantages of cost-sharing in health care and advocating its use in certain circumstances).


33 See NATIONAL ASS'N FOR HOME CARE, LEGISLATIVE BLUEPRINT FOR ACTION 1999, at 17 (1999) (arguing against the use of copayments in Medicare home health care).

34 See supra notes 25-26 and accompanying text.

35 Rice and Morrison distinguish a natural from a true experiment in the following manner: A natural experiment occurs when there is a change in the variable of interest (in this case, cost sharing) but nothing else. By examining differences in utilization before and after the change in cost sharing, one can be fairly confident that the change in cost sharing caused the changes in service use. A true experimental design, in which individuals are randomly assigned to different cost-sharing groups, is considered to be the "gold standard." If sample members accept their assignment and if there is a sufficient sample size, differences in utilization should almost certainly be the result of alternative cost-sharing requirements. Such studies, of course, suffer from one overriding impediment—they can be terribly expensive to conduct.

Rice & Morrison, supra note 30, at 237-38.
usage, provider response, and health-care outcomes. To do this, I examine the demographics and usage patterns of beneficiaries, as well as provider characteristics.

Part I of this Note presents an overview of the evolution of the home health care industry and of Medicare home health coverage. Part II then sets out the theoretical basis for cost-sharing and the touted benefits of cost-sharing in home health care, followed by normative standards by which to assess and design cost-sharing measures. Part III presents a detailed profile of home health care beneficiaries and providers. Part IV then attempts to assess the likely implications of cost-sharing for Medicare home health beneficiaries and to gauge this impact by examining how home health services compare to other medical services for which some empirical data regarding price-elasticity is available. At the core of Part IV is a discussion of the effects on demand of such factors as income, health status, and supplementary medical insurance ("Medigap policies") on demand under cost-sharing. Part V then explores the likely efficacy and normative acceptability of different cost-sharing techniques. Finally, Part VI examines alternatives to cost-sharing, assessing the nascent potential for cost-reduction in both existing and alternative measures.

I. MEDICARE AND THE HOME HEALTH CARE INDUSTRY: OVERVIEW

A. "Hospitals Without Walls": The Evolution and Definition of Home Health Care

Until recently in human history, medical care has been provided primarily in the home; the rise of institutional care in modern times prompted a counter-movement to return some forms of care to the home. In America, the development of home-based care as a viable alternative to institutional care dates back to the late eighteenth century.36 The Boston Dispensary, founded in 1796, articulated as its founding principle the goal that "[t]he sick, without being pained by separation from their families, may be relieved at home."37 Proprietary, government, and volunteer agencies, such as the Visiting Nurses Association (VNA), increasingly came to recognize the advantage of receiving care without the risks, complications, and costs of institutionalization. In 1947, Dr. E.M. Bluestone attracted further interest to this concept of care provision by founding the first "hospital without walls"—a prototype hospital-based

36 See ALLEN D. SPIEGEL, HOME HEALTH CARE I (2d ed. 1987).
37 Id. (citing T. IRWIN, HOME HEALTH CARE: WHEN A PATIENT LEAVES THE HOSPITAL (1978)).
homecare program at Montefiore Hospital in New York City. Eventually, a wide variety of medical services came to be provided in the home, including occupational and speech therapy, as well as other less obviously "medical" components of personal care.

"Home health aide" services epitomize the breadth of care that came to be provided in the home. At the beginning of this century, American charitable organizations developed a system of "visiting housewives" or "substitute mothers" to look after children and do household chores for poor families when the mother was ill. This concept of home-based personal care gained a significant boost in the 1930s, when the Works Progress Administration (WPA) employed women as "housekeeping aides" to attend distressed families. The subsequent growth of such services in the private, governmental, and volunteer sectors confirmed the place of "home health aide" services as an adjunct to home-based medical care.

The definition of "home health care" is complex and problematic, given the variety of services that have come to be encompassed by the term. The definition endorsed by four prominent national home health care organizations is as follows:

Home health service is that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated, and made available by an agency or institution, organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.

The definition of "home health services" under the Medicare statute, however, captures more of the complexity of the services provided by the industry:

The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by

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38 See id. at 3.
39 Id. at 6-7.
40 Janna Dieckmann, Home Health Administration: An Overview, in HANDBOOK OF HOME HEALTH CARE ADMINISTRATION 3, 3-4 (Marilyn D. Harris ed., 2d ed. 1997). This definition is endorsed by the Council of Home Health Agencies and Community Health Services of the National League for Nursing; the National Home Caring Council; the National Association for Home Health Agencies; and the Assembly of Outpatient and Home Care Institutions of the American Hospital Association.
such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are . . . provided on a visiting basis in a place of residence used as such individual’s home.\textsuperscript{41}

The Medicare statute goes on to list the covered services: “part-time” or “intermittent” nursing care, physical or occupational therapy and speech-language pathology services, medical social services, part time or intermittent home health aide services, and medical supplies.\textsuperscript{42} The Medicaid statute, which also covers home health care, uses in effect a similar definition.\textsuperscript{43} For the purposes of this paper, I will frequently differentiate among the various categories of services provided in the home; however, any general references to “home health care” are intended to encompass the Medicare definition of “home health services.”\textsuperscript{44}

Medicare currently provides the services outlined above to individuals meeting certain eligibility requirements. First, a physician must sign and periodically review a plan of care for the beneficiary contemplating home health services.\textsuperscript{45} Second, the patient must be homebound, or “confined to his home.”\textsuperscript{46} (Although the statute currently

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\item[41] 42 U.S.C. § 1395x(m) (1994). Under certain conditions, Medicare coverage also extends to services otherwise covered yet provided on an outpatient basis, under arrangements made by the home health agency, at a hospital, skilled nursing facility, or rehabilitation center. See 42 U.S.C. § 1395x(m)(7).
\item[42] See 42 U.S.C. § 1395x(m)(1)-(7). “Part time or intermittent” is defined by the statute as: “Skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). See 42 U.S.C. § 1395x(m).
\item[43] The Medicaid program was established under Title XIX of the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 370 (codified as amended at 42 U.S.C. §§ 1396-1396s (1994)). Further elaboration of the Medicaid statute is provided at 42 C.F.R. §§ 430-56 (1998). The Medicaid statute contemplates home health services under three general statutory provisions. For qualifying elderly, the Medicaid statute first provides for “home health care services,” 42 U.S.C. § 1396d(a)(8)(7) (1994), which are defined by the Department of Health and Human Services (HHS) as including nursing services; home health aide services; medical supplies and equipment for the home; physical and occupational therapy; and speech pathology and audiology services. See 42 C.F.R. § 440.70 (1998). Second, the Medicaid statute also covers “private duty nursing services,” 42 U.S.C. § 1396d(a)(8), which HHS has defined as “nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.” 42 C.F.R. § 440.80. Private duty nursing may be provided either in the home, in a hospital, or at an SNF. See 42 C.F.R. § 440.80(c). Third, for the “functionally disabled elderly,” Medicaid allows an expansive array of possible services provided in the home under the rubric of “home and community care.” 42 U.S.C. § 1396t(a). The services falling under this heading include such benefits as chore services, training for family members caring for the beneficiary, respite care, and adult day care. See id.
\item[44] Note that this definition leaves out hospice care, which is treated separately under the Medicare statute. See 42 U.S.C.A. § 1395x(m) (West Supp. 1999). No one has seriously argued that hospice care should be subjected to cost-sharing, even though it is administered in the home.
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provides some guidance as to the meaning of this phrase, the BBA requires the HHS Secretary to conduct a study for the purpose of elaborating this definition. Third, the patient must require one of the services falling under the definition of “home health services” above, and receive service from a Medicare-certified provider.

Moreover, the BBA enacted measures designed to increasingly transfer home health costs from Part A to Part B. The BBA stipulates that individuals with both Part A and Part B coverage can receive Part A home health services for only 100 visits per spell of illness, and only where services are provided within fourteen days of a three-day prior hospital stay or of a visit of any duration to an SNF. All other coverage for such individuals falls under Part B. This transition is intended to reduce overall Medicare expenditures by shifting more home health costs to beneficiaries through the annual Part B premium.

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47 The current definition is the following:

[A]n individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device . . . or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden . . . the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires considerable taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.


49 See supra text accompanying notes 40-41. The BBA stipulated that, if an individual requires venipuncture alone, home health administration of this service is not covered under Medicare. See Balanced Budget Act § 4615 (codified as amended at 42 U.S.C.A. § 1395n(a)(2)(A) (West Supp. 1999)).

50 See 42 U.S.C.A. § 1395x(o).

51 See Balanced Budget Act § 4611(a)-(b) (codified as amended at 42 U.S.C.A. § 1395d (West Supp. 1999)). Medicare “Part A” provides mandatory coverage for inpatient hospital care, inpatient care in a SNF, home health care, and hospice care. In contrast, Medicare Part B is optional, and beneficiaries are required to pay an annual premium. Part B coverage includes medical care and services provided by physicians and other medical practitioners, durable medical equipment, a variety of outpatient care services, and home health care services not covered under Part A. See CENTER FOR MEDICARE ADVOCACY, INC., AN INTRODUCTION TO MEDICARE COVERAGE AND APPEALS 11-19 (1998) [hereinafter MEDICARE COVERAGE AND APPEALS].

52 See Balanced Budget Act § 4611(a)-(b); see also 42 U.S.C.A. § 1395x. Such coverage is referred to as “post-institutional home health services.” See Balanced Budget Act § 4611(a)-(b).

53 See 42 U.S.C.A. § 1395d. For individuals with only Part A coverage, there are no such restrictions on coverage; Part A covers all relevant services. See 42 U.S.C.A. § 1395d(a)(3).

The passage of Medicare and Medicaid in 1965 heralded the beginning of federal funding for home health care.\textsuperscript{55} Although the Medicare statute provided little coverage initially, subsequent legislation broadened access and encouraged the development of a sizeable provider network.\textsuperscript{56} Originally conceived as a short-term, post-acute initiative, the Medicare home health program was intended primarily to help beneficiaries recover after hospital stays. As such, the program was originally covered under Part A, with no cost-sharing. However, beneficiaries could also receive Part B coverage (subject to coinsurance) without a prior hospital stay after Part A benefits were exhausted. Although the 1972 repeal of the Part B cost-sharing requirement and other measures contributed to a slight growth in program outlays during the early 1970s,\textsuperscript{57} Medicare home health expenditures under Parts A and B remained quite modest until the 1980s (see Appendix, Figure 1).

A series of legislative, judicial, and administrative actions in the 1980s ultimately paved the way for the rapid growth of Medicare home health costs in the late 1980s and early 1990s. First, the passage of the Omnibus Reconciliation Act of 1980\textsuperscript{58} abolished the three-day hospitalization requirement that had previously attached to benefits, as well as the 100-visit limit and $100 deductible.\textsuperscript{59} Perhaps most significantly, the Act permitted for-profit (proprietary) home health agencies to become Medicare-certified providers.\textsuperscript{60} In addition, the 1983 enactment of the Medicare Prospective Payment System for inpatient hospital care,\textsuperscript{61} which reduced the average length of hospital stays, increased home health usage. Under the Act, hospitals faced incentives to

\textsuperscript{55} The Medicare program is set forth in Title XVIII of the Social Security Amendments of 1965. See Social Security Amendments of 1965, Pub. L. No. 89-97, Title XVIII, 79 Stat. 286, 291-343 (codified as amended in scattered sections of 42 U.S.C.); Older Americans Act of 1965, Pub. L. No. 89-73, 79 Stat. 218. This paper focuses on the Medicare home health program, referring where appropriate to coverage under Medicaid. However, federal home health coverage is also available through the Administration on Aging, which provides in-home benefits to qualifying beneficiaries. See 42 U.S.C. §§ 3030d, 3030h-m, 3030p (1994). State-funded programs, such as Indiana's In-Home/CHOICE program, also provide coverage. See William Styring III & Thomas J. Duesterberg, \textit{The Cost Effectiveness of Home Health Care: A Case Study of Indiana's In-Home/CHOICE Program}, OUTLOOK: IDEAS FOR THE FUTURE FROM HUDSON INSTITUTE, Nov. 1997, at 3.

\textsuperscript{56} See SPIEGEL, supra note 36, at 5.

\textsuperscript{57} See LEON ET AL., supra note 32, at 6.

\textsuperscript{58} Pub. L. No. 96-499, 94 Stat. 2599.

\textsuperscript{59} Id. § 930(g), (h)(2) (codified as amended at 42 U.S.C. §§ 1395k, 1395f (1994)).

\textsuperscript{60} Id. § 930(n)(2) (codified as amended at 42 U.S.C. §§ 1395x(0)). Throughout the 1970s, public, voluntary, and nonprofit agencies had dominated the home health market, largely due to Medicare provisions disallowing certification of proprietary agencies. See LEON ET AL., supra note 32, at 6.

discharge Medicare patients earlier in the recovery period and to substitute home health and other post-acute services for hospital care. Financial pressures associated with the hospital PPS also may have prompted hospitals to generate revenue by establishing and referring patients to hospital-owned home health agencies.

The resulting spike in Medicare home health outlays prompted HCFA to restrict access through a series of instructions to Medicare fiscal intermediaries. As a consequence, program expenditures declined between 1984 and 1988, while the number of retrospective denials of payments to home health agencies rose significantly. HCFA’s restrictive interpretation of home health coverage provoked the landmark 1988 class-action suit Duggan v. Bowen. As a result of the ruling in that case, HCFA revised the Home Health Agency Manual (HIM-11) and the Medicare Intermediary Manual (HIM-13) to express a more expansive interpretation of Medicare home health coverage. Moreover, budget reductions and reduced regulatory oversight due to changes to HIM-13 also appear to have yielded increased home health spending. The cumulative effect of these judicial, legislative, and administrative actions undoubtedly generated much of the home health expansion in the late

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64 These included restricting home health services to individuals who were “homebound” and required “part-time” and “intermittent” care. See GAO, GAO/HEHS-96-16, MEDICARE: HOME HEALTH UTILIZATION EXPANDS WHILE PROGRAM CONTROLS DETERIORATE 5-7 (1996) [hereinafter GAO HOME HEALTH]. For a complete discussion of these and other instructions restricting access, see id.


67 HEALTH CARE FIN. ADMIN., DEP’T OF HEALTH & HUMAN SERVS., MEDICARE HOME HEALTH AGENCY MANUAL (Transmittal No. 222, 1989).


69 Beneficiaries now only had to require “part-time” or “intermittent” care. The definition of “homebound” was clarified, and HCFA’s clinical criteria governing home health coverage were relaxed. See GAO HOME HEALTH, supra note 64, at 5-7; KENNEY & MOON, supra note 32, at 3-5; LEON ET AL., supra note 32, at 8. For a good summary of these regulatory changes, see Komisar & Feder, supra note 18, at 6-6.

70 The HIM-13 changes made it more difficult for Medicare intermediaries to deny home health claims. Whereas before the 1989 changes, denials could be made solely on the basis of the reviewer’s general inferences about patients with similar diagnoses or on general utilization data, the revised HIM-13 required that the need for care be evaluated based on a review of the patient’s medical condition. This change made claims review (and, therefore, denials) more costly for intermediaries, reducing the number of denials. See Komisar & Feder, supra note 18, at 6-7. Furthermore, substantial reductions in Medicare’s funding for contractor medical reviews resulted in a decline in the proportion of claims to be reviewed. These funding cuts also prompted Medicare in 1995 to “drop [] a requirement that audits of home health agencies include visiting beneficiaries’ homes.” Id. at 7.
1980s and early 1990s.

However, other factors also may have played a role in encouraging the recent home health boom. One lingering "structural" problem facing the Medicare home health program is the cost-based reimbursement system, which provides little incentive for agencies to deliver an efficient amount or mix of home health services.\(^1\) Second, "the ease of obtaining and keeping Medicare certification," particularly for proprietary HHAs, "may have contributed to" the supply-side increase.\(^2\) Third, technological developments have allowed an increasing number of medical services to be supplied in the home, generating increasing demand for complex outpatient regimes.\(^3\) Fourth, many states have adopted "maximization" strategies which take advantage of the liberalized Medicare home health guidelines to leverage Medicare funds for beneficiaries who are "dual eligibles" (i.e., eligible for both Medicare and Medicaid).\(^4\) Fifth, fraud and abuse by providers have undoubtedly contributed to the rise in program expenditures.\(^5\) Finally, some have speculated that many physicians have, by simply signing the required form, effectively delegated their authority to prescribe home health care to nurses affiliated with HHAs, who have an incentive to encourage over-utilization.\(^6\)

Regardless of the factors that ultimately precipitated the increase, the Medicare home health program experienced a broad and dramatic expansion during the late 1980s and early 1990s. Expenditures rose from $3.7 billion in 1990 to $12.7 billion in 1994 (an average annual increase of 36%), increasing from 4.8% to 8.6% of total Medicare spending.\(^7\) However, the average charge per visit exhibited only a moderate increase, rising from $62 in 1988 to $84 in 1995.\(^8\) The cumulative effect on providers on the basis of cost. Under this system, "since an agency's payment limit increase[s] with the number of visits [] delivered, it ha[s] no reason to curb volume as long as the average cost per visit d[oes] not exceed the average limit. . . . Because the limits were based on national averages, [HHAs have a further] incentive to provide numerous, relatively low-cost visits within each visit type."\(^9\) Id. at 7-8.

\(^{71}\) The home health benefit is one of the few remaining Medicare programs that reimburses providers on the basis of cost. Under this system, "since an agency's payment limit increase[s] with the number of visits [] delivered, it ha[s] no reason to curb volume as long as the average cost per visit d[oes] not exceed the average limit. . . . Because the limits were based on national averages, [HHAs have a further] incentive to provide numerous, relatively low-cost visits within each visit type."\(^9\) Id. at 7-8.

\(^{72}\) Id. at 8. ("Medicare certifies nearly all [HHAs] that apply, and agencies generally retain their certification, even after being repeatedly cited for substandard care."); see also GAO, GAO/T-HEHS-97-180, MEDICARE HOME HEALTH AGENCIES: CERTIFICATION PROCESS IS INEFFECTIVE IN EXCLUDING PROBLEM AGENCIES (1997) [hereinafter GAO CERTIFICATION].

\(^{73}\) See IMPACT OF INTERIM PAYMENT, supra note 11, at 4; see also Welch et al., supra note 7, at 329.

\(^{74}\) See IMPACT OF INTERIM PAYMENT, supra note 11, at 4. This GAO study provides as an example "Minnesota's Medicare Maximization Initiative, a program designed to teach providers how to use Medicare for home health services, supplies, and equipment for [dual eligibles]." Id. at 4 n.6.

\(^{75}\) See id. at 4; see also supra notes 9-15 and accompanying text.

\(^{76}\) See Welch et al., supra note 7, at 328-29.

\(^{77}\) See LEON ET AL., supra note 32, at 9.

\(^{78}\) See KENNEY & MOON, supra note 32, at 6 tbl.1. Based on 1989-1991 data, Bishop and Skwara conclude that per visit charge increases are not the cause of Medicare home health spending growth during that period. Christine Bishop & Kathleen Carley Skwara, Recent Growth of Medicare Home Health, HEALTH AFF., Fall 1993, at 100-01.
expenditures of the changes initiated in the 1980s is depicted in Figures 1 and 2.

In addition, the years since the changes in Medicare home health policy have witnessed a transformation in the number and type of visits sought by beneficiaries, as well as in the number of Medicare beneficiaries taking advantage of the home health benefit. The number of Medicare home health beneficiaries rose from approximately 1.7 million in 1989 to 2.8 million in 1993, a 65% increase. The average number of visits per beneficiary also increased from 26.49 in 1989 to 56.71 in 1993. The mix of services provided during these visits shifted toward the less-skilled services provided by home health aides. Whereas 33.8% of all services were provided by home health aides in 1988, that figure rose to 48.7% by 1995. Moreover, the preceding trends exhibit significant geographic variation, with southern states yielding in 1996 "the highest number of persons served per 1000 enrollees (121), the highest number of visits per 1000 enrollees (11,881), and the highest number of visits per person served (98)." Proprietary agencies consistently provided more visits in all regions.

The home health industry has grown considerably over the same period. For example, the number of Medicare-certified HHAs climbed from 5785 in 1988 to 9120 in 1995—an increase of 58%. Growth in the number of proprietary agencies, which had already risen dramatically in the wake of the Omnibus Reconciliation Act of 1980, fuelled much of this supply-side expansion. The proprietary sector grew from 35.26% of all HHAs in 1989 to 48.51% in 1994. Figure 3 illustrates the transformation of the home health industry since 1980.

More fundamentally, the program has moved beyond its previous short-term, post-acute focus to encompass long-term, chronic care. For more detailed analysis of the causes of this geographic variation, see Kenney & Moon, supra note 32, at 8-12; Joshua M. Wiener & David G. Stevenson, Long-Term Care for the Elderly: Profiles of Thirteen States (The Urban Institute, Occasional Paper No. 12, 1998); Elizabeth Mauser & Nancy A. Miller, A Profile of Home Health Users in 1992, Health Care Fin. Rev., Fall 1994, at 17; and Jennifer Schore, Regional Variation in Medicare Home Health: Taking a Closer Look (visited Mar. 1, 1999) <http://www.mathematica-mpr.community/HHVEXE.htm>.

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79 See GAO Home Health, supra note 64, at 32-33.
80 See id. at 36.
81 See Kenney & Moon, supra note 32, at 7.
83 See GAO Home Health, supra note 64, at 12-13.
84 Pub. L. No. 96-499, 94 Stat. 2599. Between 1980 and 1985, the number of proprietary agencies increased from 186 to 1943 (a 945% increase). See Leon et al., supra note 32, at 10.
85 See GAO Home Health, supra note 64, at 34.
86 This transformation has been widely noted in the home health literature. See, e.g., Kenney & Moon, supra note 32, at 13; Bishop & Skwara, supra note 78; Welch et al., supra note 7, at 328. Of course, the burden of caring for the chronically ill also undoubtedly bears a causal relationship to the rise in program expenditures by exacerbating home health costs.

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example, one 1996 study revealed that 61% of home health visits in a
given sample were to enrollees receiving six or more months of home
health care, whereas only 4% received care for a month or less.87 Indeed,
chronic conditions, such as diabetes mellitus and cardiovascular disorders,
constitute the majority of diagnoses in which home health care is
employed.88 Figure 4 displays the six most prevalent diagnoses for home
health care usage. A recent study by the Kaiser Family Foundation (KFF)
further noted that in 1994 some 33% of all home health users explicitly
relied on Medicare for their long-term care needs.89 This transformation of
the Medicare home health benefit into an instrument of long-term care
arguably fills a vital need, given the virtual absence of a coherent U.S.
long-term care policy.90 However, the financial burden associated with
using home health care for chronic conditions is substantial. In 1994, the
10% of home health care users receiving 200 or more visits per year
accounted for 43% of total home health expenditures.91

Thus, despite a recent moderation in the growth of the Medicare
home health program,92 the adoption of more stringent anti-fraud
measures, and the implementation of the IPS, many believe that the
program has either already exceeded acceptable bounds or has the
potential for additional, uncontrollable growth.93 These concerns have
prompted the many recent calls for beneficiary cost-sharing, a problem to
which I now turn.

87 See Welch et al., supra note 7, at 326.
88 See id. HCFA has noted that the leading three diagnoses cited in 1996 for home health
use were diabetes mellitus, which accounted for 7.1% of all persons using HHA services, heart failure,
and essential hypertension (the latter two together accounted for 11.3% of all persons). The next three
most prevalent diagnoses were osteoarthrosis, cerebrovascular disease, and chronic airway obstruction.
Together, these 6 leading conditions accounted for approximately 30% of all persons served and 35%
of all program payments. See Medicare-Medicaid Supplement, supra note 82, at 92-93.
89 See LEON ET AL., supra note 32, at 18-19.
90 See WEINER ET AL., supra note 2, at 1-2 ("The United States does not have, either in the
private or public sector, satisfactory mechanisms for helping people anticipate and pay for long-term
care.").
91 See LEON ET AL., supra note 32, at 19.
92 See supra notes 19-20 and accompanying text.
93 See, e.g., Welch et al., supra note 7, at 328 ("Pressures on providers and patients are
likely to result in further increases in the use of home health care in the future."). In contrast to many
such predictions, HCFA's Office of the Actuary estimated that Medicare home health expenditures in
the wake of the BBA would increase between FY 1997 and FY 2002 at an annual average rate of only
0.09%. See MEDICARE PROFILE, supra note 1, at 41.
II. Cost-sharing and Home Health Care: A Theoretical Framework

A. The Theoretical Basis for Beneficiary Cost-sharing

The argument for cost-sharing is premised on neoclassical economic theory applied to patient demand for medical services. Patient demand can be expressed by a demand curve wherein quantity demanded \( Q \) varies with price \( P \); the nature of this relationship—i.e., the responsiveness of \( Q \) to \( P \)—is expressed as the elasticity of demand. The demand curve is typically an expression of a number of underlying factors, including income, “taste” (e.g., consumer perception of health services quality or consumer preference for more or less medical attention), and the price of other related commodities (i.e., either complements or substitutes).\(^94\)

Health insurance, such as Medicare, lowers the effective price borne by recipients, shifting the demand curve upwards. Holding all other factors constant, cost-sharing moderates the differential between \( Q \) before and after insurance, thereby mitigating moral hazard (see Appendix, Figure 5).\(^95\)

Three principal cost-sharing arrangements have been developed for both private and public insurance programs: deductibles, copayments, and coinsurance. A deductible requires that the patient pay all costs up to a specified maximum (e.g., the first $100 of prescription drug charges). A copayment requires that the patient pay a fixed charge per unit of medical services consumed (e.g., a $10 charge for every physician visit). Coinsurance entails the payment of some fixed percentage of a medical bill. Patient liability under any of these cost-sharing techniques or a combination thereof can be limited through the out-of-pocket maximum, wherein the patient is only responsible for cost-sharing up to a fixed total amount (for example, $500 per year); this limit may also be expressed as a percentage of income. Whether singly or in combination, these measures are expected to reduce the quantity of medical services demanded, albeit in

\(^{94}\) This model of patient demand, insurance, and cost-sharing is outlined in Philip Jacobs, The Economics of Health and Medical Care 65-114 (3d ed. 1991). See also Kenneth J. Arrow, Office of Econ. Opportunity, Optimal Insurance and Generalized Deductibles (1973); Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 Am. Econ. Rev. 941 (1963). Of course, neoclassical economic theory is much more complicated than the simple model given here, involving, inter alia, the construction of a utility function and the consideration of numerous additional variables. See, e.g., Jacobs, supra, at 91-114; Mark V. Pauly, Is Medical Care Different? Old Questions, New Answers, J. Health Pol., Pol'y & Law, Summer 1998, at 227. For a more general discussion of the principles of insurance and risk, see Carol A. Heimer, Reactive Risk and Rational Action (1985); and Allan H. Willett, The Economic Theory of Risk and Insurance (1901).

\(^{95}\) See Jacobs, supra note 94, at 81-86.
different ways and with differing degrees of effectiveness.\(^9\)

Numerous policy objectives have been adduced in support of beneficiary cost-sharing under public insurance regimes. First, cost-sharing is often held up as a means to make beneficiaries more cost-conscious, thereby encouraging them to reduce "unnecessary" use of medical services and to find less costly alternatives. Second, by encouraging beneficiaries to assess more scrupulously whether a given service is medically necessary, cost-sharing allegedly enables a more effective "policing" of providers, helping to stem fraud and abuse. The ultimate objective of this enhanced beneficiary attention to cost is to reduce the burden that the program in question exerts on the public fisc. By reducing this fiscal burden, cost-sharing allows the government to provide broader coverage than would otherwise be possible.\(^9\) Finally, cost-sharing proposals are frequently infused with the normative objective of making beneficiaries share part of the burden of care and take some responsibility for their health.\(^9\)

B. *Medicare Home Health and Cost-sharing: A Framework for Acceptability*

Is Medicare home health a viable candidate for cost-sharing? Proponents of cost-sharing have identified at least three of the benefits enumerated above: cost-sharing would (1) reduce the growing fiscal burden associated with the Medicare home health program, (2) reduce patient demand for "unnecessary" care, and (3) facilitate patient monitoring of provider recommendations for care.\(^9\) In addition, many have noted the fact that home health provision is, along with clinical laboratory services, one of the only two Medicare-covered services exempt from cost-sharing. Thus, a kind of "fairness" or program-consistency argument is often made in support of cost-sharing.\(^10\) The idea that all

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\(^9\) Note that \(Q\) is predicted to drop from the pre-cost-sharing level for two reasons: First, when the price of medical care services rises, individuals will substitute other services whose prices have not risen as quickly. Second, rising medical care services will reduce the income available to purchase all goods and services, including medical care. See Rice & Morrison, *supra* note 30, at 276 n.1.

\(^7\) These two objectives are articulated in Conrad & Marmor, *supra* note 30, at 209-11.


\(^9\) See 1999 MEDPAC REPORT, *supra* note 22, at 94 (arguing that cost-sharing would reduce program costs by requiring beneficiaries to assess more carefully the necessity of home health services, thereby deterring unnecessary use and facilitating beneficiary policing of provider recommendations); KENNEY & MOON, *supra* note 32, at 18 (noting that cost-sharing could reduce the fiscal burden associated with Medicare home health, particularly by discouraging unnecessary use).

beneficiaries must shoulder responsibility for their health care (the "responsibility argument" noted above) implicitly informs the "fairness" argument.

Three of the four objectives outlined above have clear normative appeal. Reduction of the fiscal burden associated with Medicare either frees up public resources for other government initiatives or paves the way for tax reductions. Moreover, curbing abuse and unnecessary medical services—whether patient- or provider-driven—assures that resources are used effectively and go to recipients who actually need them. However, the program consistency argument seems doubtful. Not only could it be argued that cost-sharing under Medicare is already too pervasive and burdensome, but one might reasonably conclude that there are prudential and other grounds upon which to base the home health exemption (a matter which I address in subsequent Parts). The aesthetic appeal of uniformity is not a sufficiently compelling basis for cost-sharing. Moreover, the "responsibility" argument ignores the fact that home health services only comprise a fraction of the significant health costs borne by elderly Medicare beneficiaries. Medicare home health beneficiaries are hardly receiving a "free ride" for their health care, and arguably contribute to any benefits they receive through social security and other taxes paid over the course of their lifetimes. The "responsibility" notion may also be inapt if one adopts the view that beneficiaries have a "right to health security.

101 For discussion of the philosophical and sociological issues presented by allocative decisions in medicine, see ROBERT H. BLANK, RATIONING MEDICINE (1988); Peter Conrad & Phil Brown, Rationing Medical Care: A Sociological Reflection, 10 RES. SOC. HEALTH CARE 3 (1993); and Susan D. Goold, Allocating Health Care: Cost-Utility Analysis, Informed Democratic Decision-Making, or the Veil of Ignorance?, J. HEALTH POL., POL'Y & LAW, Spring 1996, at 69. For further examination of the concept of "unnecessary" care, see infra notes 126-43 and accompanying text.

102 Beneficiaries currently face a Part A deductible of $768 for hospital visits, with a copayment of $192/day for hospital care after the 60th day. This copayment increases to $384/day for the 91st through 150th days, after which no additional copayment is paid by the beneficiary. Although there is no deductible for SNF visits, copayment charges of $96/day apply for every day after the 20th day enrolled (copayment requirements terminate after the 100th day). The annual Part B premium is $546, with a $100 deductible. Copayments for hospital and SNF stays, in particular, have been singled out for criticism as being unreasonably high and unduly burdensome. See MARILYN MOON, MEDICARE NOW AND IN THE FUTURE 147 (2d ed. 1996).

HCFA estimates that in 1996, 30.2 million Medicare beneficiaries incurred a total cost-sharing liability of $26.8 billion, with an average of $887 per person served. See Medicare-Medicaid Supplement, supra note 82, at 54. Kenney and Moon estimate the cost-sharing burden for Medicare home health users in 1996 to be much higher ($2473 per beneficiary). See KENNEY & MOON, supra note 32, at 19 tbl.5.

The United States is unusual among developed countries in employing widespread cost-sharing. According to Glaser, European countries tend not to employ much cost-sharing because their "programs were designed to encourage, not discourage, use." William A. Glaser, Financial Decisions in European Health Insurance: Lessons for the United States X-15 to X-16 (July 1988) (unpublished manuscript, New School for Social Research, Graduate School of Management and Urban Professions, on file with the author).

103 For a discussion of the health-care burden borne by the elderly, see infra notes 149-52 and accompanying text.
In addition to the three goals advocated in preceding paragraphs—reducing the burden on the public fisc, curbing unnecessary usage, and reducing fraud—I would argue that a broadly-defined understanding of "vertical equity" should inform cost-sharing design. Although the concept of "vertical equity" is most frequently articulated in discussions of tax incidence, the notion can be expressed more broadly: a person who is better off (in terms of income, health, and resources) should bear a greater proportion of the burden associated with a given public policy than one who is less well off.

This conception of relative welfare is targeted toward the protection of comparatively vulnerable beneficiaries. For present purposes, "vulnerability" is measured primarily along two axes: income and health status. Thus, cost-sharing measures must attempt to be as "income-progressive" as possible. Indeed, unless it is expressly linked to income, cost-sharing can be highly regressive. A $500 deductible, for example, is considerably more burdensome for a beneficiary with an annual income of $10,000 than for a recipient earning $100,000 a year. Indeed, none of the existing Medicare cost-sharing provisions requires an assessment of income. Income progressivity should shape judgments as to which beneficiary cohorts should bear cost-sharing burdens and to what extent. Moreover, vertical equity should apply according to health status: cost-sharing should not unduly burden the sickest and most physically vulnerable beneficiaries. However, the concept of "vulnerability" is susceptible to a broader definition where appropriate, encompassing such criteria as a beneficiary's ability to access health care and his capacity to

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104 For an assessment of the philosophical underpinnings of this idea, see generally CHARLES J. DOUGHERTY, AMERICAN HEALTH CARE: REALITIES, RIGHTS, AND REFORMS (1988).

105 For a discussion of the concept of vertical equity, see J. RONNIE DAVIS & CHARLES W. MEYER, PRINCIPLES OF PUBLIC FINANCE 120-21 (1983); and JOSEPH E. STIGLITZ, ECONOMICS OF THE PUBLIC SECTOR 400-01 (2d ed. 1988). In contrast, horizontal equity implies that those of similar means are treated similarly. As Richard Musgrave notes, "[t]he requirements of horizontal and vertical equity are but different sides of the same coin." RICHARD A. MUSGRAVE, THE THEORY OF PUBLIC FINANCE: A STUDY IN PUBLIC ECONOMY 160 (1959). Note that the interpretation of vertical equity applied in this paper implicitly rejects the adoption of one proposed method of equitable taxation: i.e., requiring that the burden be applied in proportion to the benefits one receives from a given program. Cf. WIENER ET AL., supra note 2, at 167-68 (rejecting the imposition of taxes to pay for a long-term care program by placing the tax burden on those who benefit from such a program). For an example of the application of vertical equity to health policy, see Gavin Mooney, And Now for Vertical Equity? Some Concerns Arising from Aboriginal Health in Australia, 5 HEALTH ECON. 99 (1996).

106 This fact has been widely noted. See, e.g., Thomas Rice & Kenneth E. Thorpe, Income-Related Cost Sharing in Health Insurance, HEALTH AFF., Spring 1993, at 21, 22.

107 Poor health status correlates with low income. See Rice & Thorpe, supra note 106, at 23 ("In 1990, for example, 19 percent of persons with incomes less than $14,000 rated their health as 'fair' or 'poor,' compared with 5 percent or less among those with incomes above $35,000.") (citation omitted). Thus, the requirement that cost-sharing be progressive regarding one index of welfare (i.e., health status) necessitates consideration of the other (i.e., income). For a discussion of "vulnerable populations" for health care purposes, see LU ANN ADAY, AT RISK IN AMERICA 1-14 (1993).
draw upon "informal health care," such as that provided by family members.

In addition to vertical equity considerations, which are predominantly concerned with relative welfare, cost-sharing proposals must be circumscribed by basic criteria of absolute welfare. Cost-sharing must not unduly burden beneficiaries according to either income or health status. Thus, no beneficiary should be forced into poverty or onto the Medicaid rolls as a consequence of cost-sharing. Nor should cost-sharing force beneficiaries to avoid needed care, thereby fundamentally compromising their health status. These requirements place a normative "floor" below which cost-sharing should not force beneficiaries.108

To summarize, a normatively-acceptable cost-sharing strategy is conceivable: cost-sharing may be designed to ease the burden of a public program on the public fisc by reducing unnecessary usage and targeting fraud. However, vertical equity requires that such a policy distribute the burdens of cost-sharing so as to minimize the burden on the most vulnerable populations (measured in terms of income, health status, and access to resources). Moreover, cost-sharing should not cause members of a given population to experience an unreasonably low level of income or health status.

Would cost-sharing under Medicare home health meet the preceding criteria? Obviously, a great deal depends on the specific manner in which a cost-sharing regime is designed. For example, a requirement that beneficiaries bear a 50% coinsurance burden would be prima facie unacceptable, whereas a $3 copayment per home health visit might present a more seemingly plausible scenario. However, to generate meaningful predictions as to how beneficiaries will respond to any form of cost-sharing, we must first develop a more comprehensive sense of beneficiary characteristics.

III. Beneficiary Profile

A. Demographic Characteristics and Health Indicators

A recent Kaiser Family Foundation study109 reveals that Medicare home health beneficiaries constitute some of the most vulnerable members

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108 This conception of absolute welfare arguably possesses the same normative roots as the related concern for relative welfare (vertical equity). In addition to their intuitive normative appeal, both conceptions arguably resonate with the contractarian distributive justice theories propounded by such theorists as John Rawls. See JOHN RAWLS, A THEORY OF JUSTICE 8-9 (rev. ed. 1999). For a communitarian perspective on vertical equity, see Gavin Mooney & Stephen Jan, Vertical Equity: Weighting Outcomes? Or Establishing Procedures?, 39 HEALTH POL'Y 79 (1997).

109 See LEON ET AL., supra note 32.
of the Medicare population. As Figure 6 indicates, 24.8% of beneficiaries in 1994 were eighty-five or older (compared to 9.6% of the general Medicare population). Moreover, home health recipients were more likely to be female (67.7%) and African-American (11.9%) than other Medicare recipients. These demographic characteristics have exhibited a historical tendency to correlate with lower income and health characteristics. Indeed, the KFF study affirms that 68.7% of Medicare home health users have incomes below $15,000. It is therefore not surprising that 23.8% of beneficiaries also receive Medicaid.

Medicare home health beneficiaries are also in worse health than the general Medicare population, while possessing fewer family resources to help them meet the needs of their illnesses. 57.8% of home health users rated their health status as either fair or poor, compared to 26.4% for the rest of the Medicare population. Moreover, 73% of home health users had one or more limitations on activities of daily living (ADL), and 47% had three or more limitations (compared to 11.8% of the general Medicare population). Unsurprisingly, Medicare beneficiaries who receive home health services were more likely to use the health care system generally, incurring Medicare costs that (on average) were more than five times greater than Medicare costs for beneficiaries who did not receive home health care. Moreover, 32.5% of home health beneficiaries lived alone—compared to 25.1% of the entire Medicare population—and, therefore, without the informal care provided by a live-in spouse or relative. Informal care constitutes a vital source of support for the


111 The figures in this paragraph are all taken from the KFF study. See LEON ET AL., supra note 32, at 15-16.

112 See id.

113 See id. These figures are understandable in light of the fact that, to be eligible for home health benefits, a Medicare recipient must be so limited in his faculties as to be "confined to his home." 42 U.S.C. §§ 1395f(a)(8), 1395n(a)(2) (1994).

114 See LEON ET AL., supra note 32, at 16.

115 See id. at 15-16.

116 One study of Medicare patients discharged from the hospital indicated that approximately one-third of caregivers were spouses, whereas one-half were adult children. See Rosalie A. Kane & Joan Dobrow Penrod, Family Caregiving Policies: Insights from an Intensive Longitudinal Study, in CAREGIVING SYSTEMS: INFORMAL AND FORMAL HELPERS 273, 281-82 (Steven H. Zarit et al. eds., 1993) (detailing the results of the Heinz caregiver study). Approximately 13% of the caregivers in the Heinz study were living with the patient six weeks after hospitalization. See id. at 281. These statistics, however, only track caregiving following hospital discharge, not over the longer term. Of course, the
impaired elderly population, 60-90% of whose care is given by unpaid relatives and friends.\footnote{117}

B. Distribution of Medicare Home Health Expenditures and Usage

As the KFF study reveals, Medicare home health beneficiaries include a sizable chronic, long-term care cohort. In addition to the 34% of users employing home health services in a “post-acute” capacity, the study noted that 33% of users required “long-term care,” wherein only home health care was used (i.e., with no recourse to SNF or hospital care).\footnote{118} This category of users employed significantly higher proportions of home health aide visits than the average home health user, and comprised 35% of total home health expenditures.\footnote{119} Although derived from 1994 data, this figure is identical to the proportion of total Medicare home health expenditures (35%) used in 1996 to treat the six most frequently reported diagnostic conditions: diabetes mellitus, heart failure, essential hypertension, osteoarthrosis and allied disorders, cerebrovascular disease and allied disorders, and chronic airway obstruction.\footnote{120} Each of these conditions is predominantly chronic in nature, requiring some form of long-term care; it would seem logical that a sizeable proportion of the users in the “long-term care” segment of the Medicare home health population would be afflicted with these conditions.

In contrast, the “medically complex” beneficiaries, who comprised 33% of the total user population, were generally more expensive, accounting for an estimated 42.5% of total Medicare home health expenditures (see Appendix, Figure 7).\footnote{121} The members of this beneficiary cohort were seriously ill and more likely to have functional impairments. These individuals required substantially more hospital care and, for elderly who live alone may still have access to relatives and friends living elsewhere, although the intensity and amount of care that can be provided is reduced.\footnote{117}

As to the broader elderly population, a report by the New York State Office for the Aging stated that 53% of the non-institutionalized elderly live with their spouses, 30% live alone, 15% live with other relatives, and 2% live with a nonrelative. See \textit{NEW YORK STATE OFFICE FOR THE AGING, FAMILY CAREGIVING AND ELDERLY: POLICY RECOMMENDATIONS AND RESEARCH FINDINGS} 6 (1983).

\footnote{117} Linda K. Scharer, \textit{Informal Supports, in GERIATRIC HOME HEALTH CARE: THE COLLABORATION OF PHYSICIANS, NURSES, AND SOCIAL WORKERS} 41, 41 (Philip W. Brickner et al. eds., 1997). The national economic value of informal caregiving was estimated in 1997 to be $196 billion—dwarfing the amount spent on formal home health care ($32 billion) and nursing home care ($83 billion). See Peter S. Amo et al., \textit{The Economic Value of Informal Caregiving}, \textit{HEALTH AFF.}, Mar.-Apr. 1999, at 182, 184-85. These figures only assess the market value of the informal services rendered based on the number of caregiving hours and the market wage rate, however, and do not measure such costs inflicted upon the caregiver as stress, family destabilization, impoverishment, and enhanced risk of physical and mental health disorders. See \textit{id.} at 186.

\footnote{118} \textit{See LEON ET AL.}, \textit{supra} note 32, at 16-19.
\footnote{119} \textit{See id.} at 19.
\footnote{120} \textit{See Medicare-Medicaid Supplement, supra} note 82, at 92-93.
\footnote{121} \textit{See LEON ET AL.}, \textit{supra} note 32, at 17-18.
approximately one-half of the group, were admitted to an SNF within the same year.\textsuperscript{122}

However, the KFF study also noted that the distribution of home health expenditures was disproportionately generated by a small user cohort. In 1994, these “high utilizers,” who had 200 or more visits per year, constituted only 10\% of the Medicare home health population, while accounting for 43\% of program expenditures.\textsuperscript{123} They used substantially more skilled nursing and, in particular, home health aide visits. Furthermore, the high utilizers were much more likely to be female, African-American, poor, and in poor health (see Appendix, Figure 8).\textsuperscript{124} Nearly half of the members of this group were in the “medically complex” category, while another 38\% were in the “long-term care” user cohort.\textsuperscript{125}

While these statistics offer little insight into the sources and determinants of “unnecessary care,” they provide the foundation upon which to construct an assessment of both how the burden of cost-sharing is likely to be allocated and the nature of possible beneficiary responses to cost-sharing.

IV. Cost-sharing and Medicare Home Health: Theory and Practice

Considerable uncertainty plagues any attempt to predict beneficiaries’ responses to the application of cost-sharing to Medicare home health care. To begin with, there is an inadequate number of empirical studies estimating the effects of cost-sharing on the elderly; none addresses the application of cost-sharing to Medicare home health. In the absence of direct empirical evidence, then, one might look to studies examining the elasticity of demand for various medical commodities (e.g., preventive care, acute care, dental care) in the general population. However, it is not immediately obvious which type of medical service would constitute the appropriate analogue to home health care. Moreover, unlike some medical services, there is no medical consensus regarding when home health services are “necessary.” Thus, it is difficult to distinguish unnecessary from necessary usage, undermining one of the primary stated objectives of beneficiary cost-sharing. Finally, the widespread presence of private supplemental insurance, which generally covers cost-sharing under Medicare, may further impact usage. This Part examines these problems.
A. Medical Necessity and Beneficiary Perceptions

Home health care tends to confound the paradigm of medical “necessity” or “appropriateness.” In a pioneering Health Services Utilization Study, RAND researchers designated a procedure or intervention as “appropriate” where, based upon the recommendation of a panel of experts, the “expected health benefit (i.e., increased life expectancy, relief of pain, reduction of anxiety, improved functional capacity) exceed[s] the expected negative consequences (i.e., mortality, morbidity, anxiety of anticipating the procedure, pain produced by the procedure, time lost from work) by a sufficiently wide margin that the procedure [is] worth doing.”  

Unfortunately, the application of the RAND cost-benefit approach to medical appropriateness or effectiveness is singularly problematic in the home health context. First, not only is there no consensus within the medical community over the medical benefits associated with home health services, but also these benefits may not be captured by the clinical focus of the definition. Thus, skilled nursing visits to the home in which an insulin injection might be administered, for example, seem to resonate with our conception of tasks that are in some sense “medical” and of obvious necessity to patient health and functioning. In contrast, it may be difficult to reconcile home health aide assistance in undertaking chores and other activities of daily living with our intuitions about medical treatment. Indeed, some services, such as occupational therapy and housework assistance, seem more geared toward improving patient quality of life than treating an ailment. The clinical focus of the RAND definition generally excludes broader considerations of beneficiary quality of life. However, even under the strict confines of the RAND definition, it is conceivable that certain home health aide assistance qualifies as medically “appropriate.” For example, if a patient is unable to feed himself, there is no question that the kind of assistance provided by home health aides is vital to continuing health.

The meager evidence available provides some empirical support for the medical efficacy of home health services. As a general matter, elderly patients overwhelmingly prefer to remain in the home, presumably for the independence and psychic benefits it affords them. If one is willing to

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126 Rolla Edward Park et al., Physician Ratings of Appropriate Indications for Six Medical and Surgical Procedures, 76 AM. J. PUB. HEALTH 766, 767 (1986). The RAND Corporation inaugurated “appropriateness research” in the 1980s with its Health Services Utilization Study. See Virginia A. Sharpe & Alan I. Faden, Appropriateness in Patient Care: A New Conceptual Framework, 74 MILBANK Q. 115, 115 (1996). However, this paradigmatic conception has been subjected to serious criticism. See id. at 116-20 This Note will employ the terms “necessary” and “unnecessary,” despite criticism of this terminology. See id. at 132.

127 See Sharpe & Faden, supra note 126, at 118, 126.

128 See WIENER, supra note 2, at 5, 241-42 (noting the strong preference expressed by the
move beyond the clinical focus of the RAND definition, these benefits are not insignificant. In addition, some doctors also find that the home setting provides a better environment for rehabilitation than an institutional setting. Finally, there is some evidence that home health care can reduce the need for hospitalization and acute services. However, there is ultimately no consensus in the medical community regarding the circumstances under which home health services are medically appropriate.

A related concern in determining the appropriateness of a given procedure is the presence of substitutes, a consideration that the RAND conception fails to address. Thus, if a given substitute for home health care (e.g., a SNF, hospital, or informal care) is either more beneficial to the patient or comparatively less costly to provide, one might be inclined to view the home health option as “unnecessary.” The interests of the patient and the public fisc (assuming public funding of a given medical service) arguably require that patients and providers take these considerations into account when making treatment decisions.

However, evaluating the relative medical efficacy and cost-effectiveness of alternatives can be a complicated, context-specific, and normatively problematic undertaking. For example, many beneficiary conditions are treated more effectively in a hospital setting, particularly where treatment is invasive or complex. In contrast, while many of the services provided by HHAs could be provided with equal effectiveness in inpatient and SNF settings, the latter treatment options can be considerably

elderly in surveys to remain in their homes and not to be institutionalized). For example, a 1988 Louis Harris and Associates poll noted that 78% of respondents would “prefer to receive care . . . in (their) own home.” See id. at 242; see also MARGRET K. STRAW, AARP, HOME CARE: ATTITUDES AND KNOWLEDGE OF MIDDLE-AGED AND OLDER AMERICANS (1991).

Based upon his experience with the patients treated by the Yale Geriatric Assessment Unit (YGAU), Dr. Sidney Bogardus concludes that rehabilitation therapy works better in the home. Indeed, the aim of the YGAU is to craft a plan to facilitate the return of patients to their homes. However, he concedes that it would be difficult to find hard clinical data to support his conclusions. Telephone Interview with Dr. Sidney Bogardus, Director, Yale Geriatric Assessment Unit, Yale-New Haven Hospital (Apr. 14, 1999) [hereinafter Bogardus Interview].

See, e.g., Susan L. Hughes et al., Impact of Home Care on Hospital Days: A Meta Analysis, 32 HEALTH SER. RES. 415 (1997) (concluding that home care was shown by a majority of the 412 studies analyzed to have a small-to-moderate effect on reducing hospital stays); Mary D. Naylor et al., Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders, A Randomized Clinical Trial, 281 JAMA 613 (1999) (noting that a comprehensive discharge planning process implemented by advanced practice nurses enabled home care to reduce the rate of hospital readmissions, lengthen the time between discharge and readmission, and decrease the costs of providing health care).

See Rosalie A. Kane et al., Perspectives on Home Care Quality, HEALTH CARE FIN. REV., Fall 1994, at 69, 71 (noting that “[quality assurance] in home care is at an early stage of development”); Bogardus Interview, supra note 129. Of course, this observation does not deny agreement on extreme cases. For example, an individual who fakes or exaggerates his condition to shift homemaking responsibilities onto the shoulders of a home health aide unquestionably abuses the system. Nonetheless, aside from these “ideal types,” judgments of medical necessity are problematic.
more expensive than home health care.\textsuperscript{132} The complexity of these kinds of judgments is compounded by the question of whether the costs under consideration are solely those borne by the public fisc or whether they include other, often non-quantifiable costs (including those borne by caregivers). While policy-makers may be tempted to force home health users to rely on informal and family-provided care to reduce the burden on the public fisc, the resulting care burden can exert a considerable strain on family emotional and financial resources.\textsuperscript{133} Finally, the medical "necessity" of a given procedure is unclear where the objectives of medical efficacy and cost-effectiveness conflict. Where a given procedure is more effectively administered in the home, yet costs the Medicare program more to administer in that setting, how does one decide? The dilemmas discussed in this paragraph—i.e., whether to place the care burden on the patient's family and whether to prefer patient welfare to budgetary considerations—reveal the centrality of values in judgments regarding medical necessity.\textsuperscript{134}

As the preceding discussion indicates, considerable uncertainty clouds efforts to discern the "objective" necessity of home health services. Does this imply that the concepts of appropriateness and medical necessity are meaningless in the home health context? Far from it. First, I assume a definition of "appropriateness"\textsuperscript{135} that includes both the RAND criteria and broader quality-of-life considerations. In addition, I assume that "appropriateness" encompasses an evaluation of alternatives in terms of cost- and medical-effectiveness. If we assess appropriateness in this fashion, it is not difficult to conceive of limiting cases where home health services are, indeed, "unnecessary." For example, if a moderately arthritic

\textsuperscript{132} The American National Hospital Panel Reports indicate that in 1994, the average inpatient operating expense per hospital day was $1060. See Carolyn S. Donham et al., \textit{Health Care Indicators}, 16 \textit{HEALTH CARE FIN. REV.} 295, 302 tbl.1 (1994). Furthermore, SNF costs can be as high as $46,000 per year. See \textit{The Advocate's Toolkit: Talking Points} (visited May 15, 1999) <http://www.ltccampaign.org/advocate/case.htm>. In contrast, home health care cost an average of $84 per visit in 1995. See \textit{Kennedy & Moon, supra} note 32, at 6 tbl.1. Assuming that a patient were to use home health services 365 days per year, the total annual cost at the preceding rate would be $30,660. Of course, unlike home health care, SNF expenditures include meals, housing, and other costs, in addition to medical services. But see William G. Weissert et al., \textit{The Past and Future of Home- and Community-Based Long-Term Care}, 66 \textit{MILBANK Q.} 309 (1988) (arguing that home care only produces minimal therapeutic benefits and may even increase overall cost when compared to SNF).


\textsuperscript{134} See Sharpe & Faden, \textit{supra} note 126, at 119 ("[T]he concept of appropriateness is fundamentally evaluative. It is variously informed by the norms and values of science, of medicine, of individuals, and of society. Determinations of the appropriateness of a procedure therefore should not be regarded simply, or even primarily, as an evidentiary problem . . . but rather as a problem of values assessment.").

\textsuperscript{135} I employ the terms "appropriateness" and "medical necessity" interchangeably.
elderly Medicare beneficiary were to receive home health aide assistance in cleaning, bathing, eating, and household chores seven days per week, one might be dubious of the value of such services in light of the beneficiary’s modest impairment. One might also suspect that less-costly alternatives, such as self-care and informal care, could supplant formal home care at minimal cost to the patient and/or his friends and relatives.\textsuperscript{136} Aside from this type of limiting case, however, more clinical work needs to be undertaken before meaningful criteria for both medical- and cost-effectiveness can be derived. Central to such an undertaking is a more explicit statement by Congress of the values that are to animate Medicare payment policy. Given the inherently value-laden nature of appropriateness judgments, authoritative normative guidance is required.

However, even if one were able to arrive at meaningful criteria for assessing appropriateness decisions in the home health context, any cost-sharing regime would have to confront the fact that beneficiaries—the targets of cost-sharing—may lack the information necessary to make judgments according to these criteria.\textsuperscript{137} As a general matter, any patient facing the prospect of medical treatment confronts multiple sources of uncertainty. As Kenneth Arrow writes:

Uncertainty as to the quality of the product is perhaps more intense [in medicine] than in any other important commodity. Recovery from disease is as unpredictable as its incidence. In most commodities, the possibility of learning from one’s own experience or that of others is strong because there is an adequate number of trials. In the case of severe illness, that is, in general, not true; the uncertainty due to inexperience is added to the intrinsic difficulty of prediction.\textsuperscript{138}

Moreover, there is an asymmetry of information between doctor and patient. The doctor is presumably much better informed about the patient’s condition and about what treatment is required than is the patient; both doctor and patient are aware of this asymmetry.\textsuperscript{139}

The patient may, therefore, be inclined to defer to the doctor or nurse’s recommendations regarding needed care. As was mentioned

\textsuperscript{136} However, it is difficult to see how that particular scenario could occur in reality, given that the patient still has to qualify as “homebound” and receive a doctor’s certification of necessity. See supra notes 61, 66, 109 and accompanying text. It is conceivable that a beneficiary might legitimately need such assistance and yet lack effective recourse to any of the substitutes for home health care. In such cases, the financial burden associated with cost-sharing might lead him to decline truly necessary care and suffer the medical consequences. See infra notes 160-68 and accompanying text.

\textsuperscript{137} For those beneficiaries whose cognitive impairments require a caregiver or guardian to make medical decisions on their behalf, the same difficulties apply.

\textsuperscript{138} Arrow, supra note 94, at 951; see also Conrad & Marmor, supra note 30, at 211.

earlier, providers (particularly nurses) may have an incentive to over-prescribe; patient deference amidst this uncertainty would then result in excessive care. Moreover, home health care lacks many of the built-in deterrents to over-use that characterize other medical services not subject to cost-sharing; these natural barriers include transportation costs, the cost of lost time (in wages or leisure), and the pain sometimes associated with medical care. In addition to the absence of these constraints, it is also possible that certain patients may possess an exaggerated sense of their own condition, exhibiting a preference for more intensive care than is perhaps warranted. These patients might therefore either acquiesce in the provider's possibly inflated recommendation or demand additional care.

However, cost-sharing could, in theory, cause patients either to refrain from pushing for additional care or to reject provider recommendations. If the financial disincentives are great enough, patients may even reject care that both they and the provider perceive as central to health maintenance. Alternatively, if the beneficiary perceives the treatment to be sufficiently important, he may simply maintain home health usage and absorb the financial consequences of cost-sharing. Beneficiaries' financial status and cognitive capacity will further affect their reactions to cost-sharing, as will the availability and perceived cost of substitutes such as SNF, hospital, and informal resources.

Thus, the uniquely high degree of uncertainty associated with determining the medical "necessity" of home health services compounds the difficulty of predicting how the conflicting incentives and factors facing beneficiaries will affect their reaction to cost-sharing. More fundamentally, patients' difficulty in perceiving which services are "necessary" makes the findings of the RAND Health Insurance Experiment (HIE) even more salient—i.e., that cost-sharing tends to reduce in equal amounts the use of both necessary and unnecessary medical services. Far from being a precise means of paring away unnecessary use, cost-sharing is therefore likely to be a relatively blunt instrument, having indiscriminate and somewhat arbitrary effects on beneficiaries.

Although reaction to cost-sharing will differ among patients and beneficiary cohorts, I will trace general tendencies in light of the characteristics of the beneficiary population. In subsequent Sections, I will also examine whether cost-sharing scenarios involving other medical

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140 See supra note 73 and accompanying text.
141 These built-in demand constraints on "free care" usage are outlined in Conrad & Marmor, supra note 30, at 209.
142 See Rice & Morrison, supra note 30, at 251-52.
services, which have been the subject of empirical study, shed any light on this subject.

B. **Home Health Care and Other Medical Services: Empirical Evidence**

Although they have been criticized for design and data-collection flaws, a number of studies have examined the impact of cost-sharing on both the use of medical services and health outcomes. Unfortunately, little empirical work has been done on the effects of cost-sharing on the elderly, and no study has examined the response of elderly home health beneficiaries to cost-sharing. In this Section, I will explore the ways in which existing studies in cost-sharing shed light on the possible response of the Medicare home health beneficiary population.

Different medical services tend to elicit different demand elasticities; although trying to compare demand responsiveness among studies is an inherently treacherous undertaking, a rough rank-ordering can at least be attempted for some of the principal medical service categories. As a Stanford University experiment revealed, adults exhibit highly elastic demand patterns vis-à-vis preventive services such as physical exams; for example, adult nonprofessional males reduced the number of physical examinations sought by 51% when 25% coinsurance was introduced. Emergency room visits and inpatient care seem to be the next most elastic medical services. In the RAND HIE, patients facing 25% coinsurance for emergency room services had approximately 33% fewer visits than those without cost-sharing. The United Mine Workers’ (UMW) health plan study conducted by Scheffler found that the probability of hospitalization dropped 29.4% under a more draconian cost-sharing arrangement.

144 As Thomas Rice and Kathleen Morrison note, these studies frequently lack sufficient data (particularly due to the predominantly cross-sectional nature of their design) and encounter selection bias. Rice & Morrison, supra note 30, at 237-38.

145 For an exception to this gap in the literature, see infra note 164.

146 This natural experiment, conducted at Stanford University in the late 1960s, revealed that, among nonprofessional adult males, physical examinations fell by 51.2% when a 25% coinsurance requirement was introduced. For professional and faculty males, the decline was slightly less than 25%. See Anne A. Scitovsky & Nelda M. Snyder, *Effect of Coinsurance on the Use of Physician Services*, SOC. SECURITY BULL., June 1972, at 3, 16 tbl.13; see also Anne A. Scitovsky & Nelda McCall, *Coinsurance and the Demand for Physician Services: Four Years Later*, SOC. SECURITY BULL., May 1977, at 19. For a critical assessment of this study’s methodology and its applicability to contemporary conditions, see Charles E. Phelps & Joseph P. Newhouse, *Effect of Coinsurance: A Multivariate Analysis*, SOC. SECURITY BULL., June 1972, at 20; and Rice & Morrison, supra note 30, at 240.

147 See HIE, supra note 143, at 152-65. The HIE was conducted in the 1970s and early 1980s by the RAND Corporation and used a true experimental design to determine the responsiveness of use and cost to various cost-sharing arrangements. The effects of cost-sharing on health outcomes were also examined. Although the literature critically examining this landmark study is vast, a useful introduction to the methodological limitations and advantages of the study is in Rice & Morrison, supra note 30, at 240-48.

148 See Richard M. Scheffler, *The United Mine Workers’ Health Plan: An Analysis of the
Dental visits, prescription drugs, and physician visits exhibited smaller elasticities, yet were relatively similar in magnitude. The HIE study revealed that there were roughly 27% fewer dental visits under a 25% coinsurance requirement. Prescription drugs exhibited similar elasticities, although they differed slightly according to the effect on cost and on use. The HIE indicated that individuals under 25% coinsurance were only 23% less likely to fill a prescription, whereas expenses on prescription drugs were likely to be approximately 30% less. As regards physician visits, the Stanford study indicated 24% fewer visits per capita for patients facing 25% coinsurance. Under the cost-sharing provisions of the UMW study, the probability of patients obtaining physician visits was shown to have declined by 36%.

The challenge, ultimately, is to determine which medical service most closely resembles home health care, holding all other factors constant. However, to draw meaningful comparisons, it is necessary to postulate the causal mechanisms underlying the differences in elasticities among the five medical services outlined above. Clearly, the presence of substitutes and the price differential among different types of medical services drives some of the differential. For example, given their prophylactic nature, preventive services typically do not present the patient with an immediately pressing need; faced with cost-sharing, the patient may be more likely to defer such services or forego them altogether. Moreover, many inpatient services can be provided through the less-expensive physician visit, encouraging substitution. Patients may be less willing to substitute in the other direction (i.e., substitute inpatient for physician services), given the difference in cost.

Examination of the treatments associated with the six most-commonly diagnosed conditions for which home health services were employed might indicate whether some of the same causal factors are at play. These six conditions—diabetes mellitus, heart failure, essential

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Cost-sharing Program, 22 MED. CARE 247, 249 tbl.1 (1984). Scheffler examined a natural experiment in cost-sharing. In 1977, the UMW health plan introduced a $250 annual inpatient hospital deductible and a 40% coinsurance rate on physician and most outpatient services, with an annual out-of-pocket maximum of $500 per family. See id. at 247. For subsequent studies of the UMW case, see Marianne C. Fahs, Physician Response to the United Mine Workers' Cost-Sharing Program: The Other Side of the Coin, 27 HEALTH SERV. RESEARCH 25 (1992); Pamela C. Roddy et al., Cost Sharing and the Use of Health Services: The United Mine Workers of America Health Plan, 24 MED. CARE 873 (1986). For a discussion of the methodological strengths and weaknesses of the preceding studies, see Rice & Morrison, supra note 30, at 249-51.

149 HIE, supra note 143, at 51-60.
150 Id. at 165-68.
151 See Scitovsky & Snyder, supra note 146, at 12 tbl.11. Physician visits for minor complaints ("general practice" services) fell by 22% under cost-sharing. See id.
152 See Scheffler, supra note 148, at 251.
153 Indeed, the HIE results provide further confirmation of the reluctance of patients to substitute inpatient for outpatient services generally. HIE, supra note 143, at 172-76.
hypertension, osteoarthrosis, cerebrovascular disease, and chronic airway obstruction— are largely chronic, requiring a mixture of skilled and unskilled care. Unfortunately, none of these studies specifically addressed the response of the chronically ill to cost-sharing. Moreover, the overall physical condition and care requirements of individuals with these illnesses vary considerably depending on the severity of the ailment. Thus, diabetics—the largest group of home health recipients—may require ostensibly skilled care in the form of assistance in monitoring their blood sugar levels and delivering injections. However, they may also require additional home health aide assistance with activities of daily living, depending on the severity of their conditions (i.e., if their conditions are compounded by strokes or cognitive disorders). The severity and nature of their conditions also dictate the extent to which diabetics would be able to substitute formal care with self-care by, for example, administering injections themselves. The pain and difficulty they might experience in conducting self-care would further raise the effective “price” of self-care as a substitute. Furthermore, the accessibility of relatives and family members would further dictate the extent to which informal care could be substituted for formal home health care. The severity of the patient’s debilitation would also determine the burden that might be imposed on informal caregivers through substitution, determining the “relative price” (often perceived in non-monetary terms) affecting the decision of when and how much to substitute. Thus, the availability and effective “price” of substitutes can only be determined through highly context-sensitive judgments contingent on a number of factors specific to beneficiary characteristics. Generalizations as to the similarity between home health care and other medical services are therefore deeply problematic.

C. Beneficiary Characteristics and Demand Response

1. Income

The lower incomes of Medicare home health beneficiaries might lead them to be exceedingly responsive to cost-sharing. As the KFF study revealed, the incomes of Medicare home health beneficiaries are markedly lower than those of the larger Medicare population. As a general matter, non-institutionalized Medicare beneficiaries spend an average of 21% of their incomes on health care, with Medicare covering only 55% of their

154 See supra note 88.
155 See id.
156 See Bogardus Interview, supra note 129.
total health care costs. As the KFF study indicates, Medicare home health beneficiaries incur significantly greater health care costs than members of the larger Medicare population. Given the extent of their physical impairment, the long-term care and "medically complex" Medicare home health beneficiaries undoubtedly spend an even higher percentage of their income on out-of-pocket health care costs. Like other Medicare beneficiaries, members of these vulnerable cohort groups face high copayments and deductibles for most Medicare services, as well as other non-covered health care costs, including increasingly burdensome prescription drug costs. In light of their precarious financial situation, therefore, one might expect Medicare home health beneficiaries—particularly the long-term care and medically-complex beneficiaries—to be highly responsive to cost-sharing.

The empirical literature on cost-sharing seems to bear out the predicted responsiveness of low-income beneficiaries. While the HIE and the Scitovsky studies did not indicate a significant relationship between income and the use of medical care, the 1972 Scitovsky-Snyder study offered some evidence to indicate that lower-income persons were less likely than other income cohorts to see a physician after the introduction of cost-sharing. Moreover, studies of the effects of introducing cost-

158 See supra text accompanying note 114.
159 A recent study by the National Academy of Social Insurance asserted that half of all people on Medicare have out-of-pocket prescription drug expenses of less than $200 per year. However, the study also noted that 4.5 million Americans spend $1000 or more annually on prescription drugs, while at least 1.3 million spend over $2000 per year. Anecdotal evidence suggests that many seniors are forced to choose between food and prescription drugs. See William M. Welch & Susan Page, Drug Benefit Newest Twist in Debate over Medicare, USA TODAY, Apr. 29, 1999, at 1A. Moreover, the Medicare Board of Trustees estimates that 40% of Medicare beneficiaries will lack any coverage for prescription drug costs by the year 2000. Currently, only three Medigap policies cover prescription drugs. See id. at 2A. For a discussion of the literature examining the health-care costs faced by the elderly, see generally Gary L. Gaumer & Joanna Stavins, Medicare Use in the Last Ninety Days of Life, 26 HEALTH SERV. RES. 725 (1992).
160 The KFF study revealed that 19.6% of the "long-term care" cohort had incomes of $5000 or less (compared to 14.3% of the rest of the Medicare home health population). Although the difference is slight, 56.7% of the long-term care group had incomes between $5000 and $15,001, as compared to 55.5% for the larger Medicare home health beneficiary pool. While fewer "medically-complex" users faced the extremely low incomes of $5000 or less (11.5%) than members of the long-term care group, more had incomes in the next bracket (60%). See LEON ET AL., supra note 32, at tbl.4a.
161 The rationale for this inference may seem obvious. As Rice and Morrison state, "[t]he effect of cost sharing on the poor may be stronger because seemingly minor financial requirements may constitute a significant proportion of disposable income." Rice & Morrison, supra note 30, at 253.
162 See HIE, supra note 143, at 45-47; Willard G. Manning et al., Health Insurance and the Demand for Medical Care Utilization: Evidence from a Randomized Experiment, 77 AM. ECON. REV. 251, 269 (1987).
163 The Scitovsky-Snyder study found that faculty use of physician visits declined 23.1% following the introduction of coinsurance; professional and nonprofessional staff witnessed 25% and 24.4% declines, respectively. Scitovsky & Snyder, supra note 146, at 8 tbl.5. When adjusted for age,
sharing into California’s Medicaid programs (Medi-Cal) in 1972 provided further evidence that relatively small copayments resulted in the use of less outpatient care.\textsuperscript{164} Finally, two Canadian studies confirm the heightened responsiveness of lower-income users to cost-sharing.\textsuperscript{165}

Of greater concern is the enhanced likelihood demonstrated by the empirical literature that cost-sharing will diminish the health status of lower-income beneficiaries. Under the HIE, for example, lower-income participants facing cost-sharing experienced higher diastolic blood pressure, greater risk of death, and the use of fewer highly effective medical services.\textsuperscript{166} The Medi-Cal experience also demonstrated that the reduced utilization of outpatient care among lower-income beneficiaries due to cost-sharing resulted in higher hospitalization rates.\textsuperscript{167}

the figures for faculty, professionals, and nonprofessionals were 24.7%, 23.5%, and 27.4%, respectively. See id. Given that nonprofessionals typically exhibit income levels that are significantly lower than those of faculty and lower (albeit to a lesser extent) than those of professional employees, the preceding results provide tentative confirmation of a positive correlation between income and physician visits when coinsurance is imposed.

Moreover, the study indicated that nonprofessional staff were more likely to have zero physician visits following the introduction of coinsurance. The percentage of nonprofessionals without a single physician visit increased from 14.4\% before coinsurance to 25.5\% after its introduction (an increase of 77.1\%). See id. at 11 tbl.9. For comparison, 22.1\% of professional staff and 15\% of faculty did not use a physician visit in the wake of coinsurance—an increase from previous levels of 47.3\% and 31.6\%, respectively. See id.

\textsuperscript{164} See Earl W. Brian & Stephen F. Gibbens, California’s Medi-Cal Copayment Experiment, 12 MED. CARE 4, 28-34 (Supp. 1974) (noting that a $1 copayment appeared to reduce the use of certain preventive services, yet was a less serious deterrent for those with more serious medical conditions); Jay Helms et al., Copayments and Demand for Medical Care: The California Medicaid Experience, 9 BELL J. ECON. 192, 192 (1978) (noting an 8\% decrease in physician visits); Milton I. Roemer et al., Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish, 13 MED. CARE 457, 465-66 (1975) (finding that copayments reduced utilization of physician office visits, urinalysis, and pap smears); see also Rice & Morrison, supra note 30, at 255-57.


A 1980 survey showed that, faced with “extra billing,” lower-income persons were more likely than higher-income persons to report that they reduced their use of physician services or delayed seeking care. See G.L. Stoddart & C.A. Woodward, The Effect of Physician Extra Billing on Patients’ Access to Care and Attitudes Toward the Ontario Health System 9 (May 1980) (unpublished manuscript, on file with the McMaster University Library).

There are undoubtedly risks in applying data from the experiences of the Canadian system, given the differing composition of its medical sector, its unique demographic characteristics, etc. However, the “low-income effect” exhibited in these studies merely underscores the evidence from American studies. Moreover, in light of the numerous changes in the U.S. health-care market over the past thirty years, one might argue that it is equally hazardous to apply results from American studies in the 1970s to the present day. Ultimately, the paucity of empirical research in this area leaves one with little choice but to look at all available data.

\textsuperscript{166} HIE, supra note 143, at 183-243; see also Robert H. Brook et al., Does Free Care Improve Adults’ Health? Results from a Randomized Controlled Trial, 309 NEW ENG. J. MED. 1426, 1432-33 (1983).

\textsuperscript{167} See Helms et al., supra note 164, at 200 (noting a 17\% increase in total MediCal
On the basis of the preceding evidence, one might conclude that Medicare home health beneficiaries would react to cost-sharing by significantly reducing their home health usage, with possibly deleterious health consequences. Particularly given the questionable availability and effectiveness of substitutes for home health care in many instances, the beneficiaries may simply reduce needed care.

2. Health Status

The effect of health status on the use of health services is more difficult to predict. It might be supposed that sicker individuals would be less responsive to cost-sharing, given their more pressing need for care. In light of the seriously compromised health status of Medicare home health beneficiaries, one might similarly infer low price-elasticity. However, the HIE demonstrated that coinsurance reduced service usage in roughly equal amounts for the healthy and the sick, undermining this hypothesis.

Alternatively, one might predict that the chronically-ill segment of the Medicare home health population would be unresponsive or only marginally responsive to cost-sharing. Medicare home health services may be perceived by long-term care beneficiaries as central to their well-being, given that their medical needs and ADL limitations may require home health services on a daily basis. Unfortunately, there is little evidence indicating how the chronically-ill react to cost-sharing. One of the Medi-Cal studies might provide loose confirmation of the above hypothesis, as it indicated that the greater the significance of a health service to the patient, the less that cost-sharing reduced usage. In addition, a study by Link et al. indicated that the elimination of Medicare cost-sharing through Medigap insurance increased the number of physician visits by the non-chronically-ill by 42%; for those with at least one chronic condition, this increase was only 5%. Thus, the presence of cost-sharing may have little hospitalization time after imposition of a $1 copayment for physician visits); Roemer et al., supra note 164, at 462-65 (observing that hospitalization rates increased more for those facing copayments than for those without cost-sharing).

168 As noted earlier, SNF and hospital care are typically much more expensive than home health care, and the elderly overwhelmingly prefer home treatment to institutional care. In addition, the quality of informal care is often lower than that provided by HHAs. Moreover, self-care may not be a viable substitute for some beneficiaries due to their physical impairments. Finally, beneficiaries may not judge accurately when a given substitute is medically appropriate or when reduction of usage can be undertaken safely. See supra notes 128-36 and accompanying text.

169 See Kathleen N. Lohr et al., Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial, 24 MED. CARE S1, S36-$37 (Supp. 1986).

170 See Brian & Gibbens, supra note 164, at 40-41.

171 See Charles R. Link et al., Cost Sharing, Supplementary Insurance, and Health Services Utilization Among the Medicare Elderly, 2 HEALTH CARE FIN. REV. 25 (1980); see also Sandra Christensen et al., Acute Health Care Costs for the Aged Medicare Population: Overview and Policy.
impact on usage among chronically-ill Medicare home health beneficiaries.

In sum, the income and health characteristics of the Medicare home health population tend to cut in opposite directions (at least for chronically-ill beneficiaries): one would expect lower income to yield high responsiveness to cost-sharing, whereas the need for long-term care may render demand relatively inelastic. The ultimate resolution of these conflicting tendencies is likely to be highly context-specific, and it would probably require rigorous empirical work for a firm conclusion to be established. However, under either scenario (i.e., reduced usage or constant usage), vertical equity concerns are apparent. On the one hand, if they maintain their pre-cost-sharing levels of home health usage, beneficiaries—particularly long-term-care and medically-complex individuals, whose usage is more intense than that of the rest of the population—would bear an enhanced, significant economic burden because of cost-sharing. On the other hand, if beneficiaries ultimately reduce their usage of home health services, they may experience a less profound economic effect, yet their health may be at risk due to the reduced usage. Thus, cost-sharing raises serious vertical equity concerns along both the income and health axes.

D. Supplemental Insurance

One might argue that the vertical equity considerations described above have less or no salience given the availability of private supplemental ("Medigap") insurance policies, which cover cost-sharing under Medicare. Since the Omnibus Budget and Reconciliation Act of 1990 (OBRA 90), Medigap issuers have been required to offer policies that conform to one of up to ten specific prototypes, offering varying levels of benefits at correspondingly different premiums. One study estimated that approximately 75% of the elderly had some form of private insurance to supplement Medicare: 37% of the elderly were shown to possess only Medigap policies, 33% had only employer-sponsored policies, and 5% were covered under both types. However, HCFA

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*Options*, 65 *Milbank Q.*, 397, 421-24 (1987) (noting that use of both inpatient and physician services among Medigap enrollees is 24% higher than for those without supplementary coverage).


173 For a good discussion of the various policies mandated by OBRA 90, see Thomas Rice & Kathleen Thomas, *Evaluating the New Medigap Standardization Regulations*, HEALTH AFF., Spring 1992, at 194.

174 See Chulis et al., supra note 31, at 17. Employer-sponsored insurance is less prevalent among beneficiaries with lower incomes. Only 6.1% of beneficiaries with incomes of $5000 or less have employer-sponsored insurance. 15% of beneficiaries with incomes between $5000 and $10,001 have such plans, while the figure for Medicare recipients with incomes between $10,000 and $15,001
estimates that roughly 11% of Medicare beneficiaries have neither private supplementary insurance nor Medicaid coverage, exposing them to full cost-sharing liability.\textsuperscript{175} Moreover, approximately 200,000 Medicare home health beneficiaries lack both public and private supplemental coverage.\textsuperscript{176} Of greatest concern are the “high-utilizers,” who use 200 or more home health visits per year and, therefore, face the most significant cost-sharing burden; the KFF study noted that, in 1994, only 57.5% of these individuals had Medigap coverage.\textsuperscript{177} Kenney and Moon estimate that a 20% coinsurance requirement applied in 1996 would have yielded an annual cost increase of $1228 for the average Medicare home health user.\textsuperscript{178} For beneficiaries lacking private supplemental coverage, such a burden could be significant indeed.\textsuperscript{179}

Even for those beneficiaries who possess Medigap insurance, a rise in premiums resulting from increased cost-sharing would place an additional burden on incomes already strained by high health care costs. By one estimate, assuming a 20% coinsurance rate applied to home health benefits and a 20% administrative load, yearly premiums for Medigap policies would have increased by roughly $113 in 1996.\textsuperscript{180} In addition, the increasing prevalence of age-rating in Medigap insurance would place an even greater burden on recipients over age eighty-five, who would face a premium increase of approximately $300.\textsuperscript{181} Given that some 25.5% of Medicare home health beneficiaries and 29.6% of long-term care users are over eighty-four years old,\textsuperscript{182} this burden may apply to a substantial number of the most physically frail and low-income home health

\textsuperscript{175} See Medicare-Medicaid Supplement, supra note 82, at 48. Medicaid does not generally impose cost-sharing requirements on beneficiaries. For further discussion, see infra notes 176-82 and accompanying text.

\textsuperscript{176} See \textit{KENNEY & MOON}, supra note 32, at 20. The KFF study noted that, in 1994, only 70.1% of home health beneficiaries had a private Medigap policy. See \textit{LEON ET AL.}, supra note 32, at tbl.3.

\textsuperscript{177} See \textit{LEON ET AL.}, supra note 32, at tbl.5a. It is not surprising that persons with worsened health outcomes requiring more intense home health services should have reduced access to Medigap coverage. As Karen Davis notes, “[w]ith some important exceptions, MediGap plans often deny coverage to elderly people with pre-existing conditions.” \textit{KAREN DAVIS, COMMONWEALTH FUND, MEDICARE: OPTIONS FOR THE LONG TERM 8} (1997).

\textsuperscript{178} \textit{KENNEY & MOON}, supra note 32, at 19. The authors note, however, that this estimate should be treated with some care, as these simulation numbers were drawn from a relatively small sample in the Medicare Current Beneficiary Survey. \textit{Id.} at 20 n.14.

\textsuperscript{179} For a discussion of the income characteristics of home health beneficiaries, see \textit{supra} text accompanying note 111; and \textit{infra} text accompanying notes 187 and 197. The average cost-sharing burden faced by home health users in 1996 was $2473. See \textit{KENNEY & MOON, supra note 32}, at 19 tbl.5; see also \textit{supra} note 102.

\textsuperscript{180} See \textit{KENNEY & MOON, supra note 102}, at 20; \textit{see also MOON, supra note 102}, at 159-61 (discussing the cost-savings and burden on beneficiaries associated with possible increases in the Part B premium).

\textsuperscript{181} See \textit{KENNEY & MOON, supra note 32}, at 20.

\textsuperscript{182} See \textit{LEON ET AL.}, supra note 32, at tbl.4a.
beneficiaries.

E. Medicaid

1. Medicaid-Only Dual-Eligibles

One might view Medicaid coverage as a factor mitigating the vertical equity considerations noted in previous Parts. Thus, members of the "dual-eligible" population—i.e., those who are eligible for both Medicare and Medicaid funding—could employ Medicaid reimbursement for home health services to avoid Medicare cost-sharing. Indeed, the 1994 KFF study confirmed the results of a previous study, finding that 24% of Medicare home health users were also eligible for Medicaid. As one would expect, increasing usage of home health services positively correlates with dual eligibility. Thus, the KFF study noted that 27% of "long-term" care users—whose elevated health-care costs tend to produce lower incomes than those of other cohorts—were dual-eligible. Moreover, the KFF study noted that 34.5% of the "high utilizers" with 200 or more home health visits per year were dual-eligible. In contrast, another study found that 45% of this same Medicare home health cohort were eligible for Medicaid.

However, a significant portion of the home health population possesses incomes that are low enough for cost-sharing to present a burden, but still fails to qualify for Medicaid. Whereas 24% of home health beneficiaries were estimated by the KFF study to be Medicaid dual-eligible in 1994, 69.8% of the home health population had annual incomes at or below $15,000. 45.8% of Medicare beneficiaries, therefore, have incomes at or below $15,000, yet fail to qualify for Medicaid. Given that the 1994 poverty threshold for an individual over age sixty-five was $7108, the impact of cost-sharing on those individuals falling outside the Medicaid umbrella may be significant indeed.

183 See id. These results are identical to the results of Mauser and Miller's 1992 study of Medicare home health beneficiaries, which found that 24% of Medicare home health users were dual-eligible. See Mauser & Miller, supra note 82, at 20.
184 See LEON ET AL., supra note 32, at tbl.4a.
185 See id. at tbl.5a.
186 See Mauser & Miller, supra note 82, at 20.
187 See LEON ET AL., supra note 32, at tbl.5a.
2. "Medicaid Estate Planning"

Alternatively, one might argue that "Medicaid estate planning" would allow many Medicare beneficiaries to "shelter or divest their assets" to relatives "without first depleting their life savings," thereby qualifying for Medicaid coverage and evading Medicare home health cost-sharing without "real" impoverishment. However, Congress has enacted a number of measures criminalizing and restricting the availability of such techniques. More importantly, the low incomes of the elderly population make it unlikely that they would have either the incentives or the sophisticated information necessary to engage in Medicaid estate planning. Indeed, the available evidence confirms the restricted availability of such planning techniques, despite numerous allegations to the contrary. Thus, the possibility that a few beneficiaries might have recourse to Medicaid estate planning fails to mitigate the concerns articulated above regarding cost-sharing.

3. The Qualified Medicare Beneficiary Program

Another possible means of mitigating the effects of Medicare home health cost-sharing is through the Qualified Medicare Beneficiary (QMB) program. Medicare beneficiaries who do not qualify for Medicaid, yet have incomes up to the federal poverty level and resources that are no more than twice the Supplemental Security Income (SSI) resource level, qualify for state coverage of all deductibles, coinsurance, and premiums under Medicare Parts A and B. Unfortunately, information concerning

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191 See Joshua M. Wiener, Can Medicaid Long-Term Care Expenditures for the Elderly Be Reduced?, 36 GERONTOLOGIST 800, 803 (1996).
192 See id. at 802-03.
193 See 42 U.S.C.A. § 1396d(p) (West Supp. 1999); see also 42 C.F.R. § 409.5 (1994). Whereas individuals receiving these benefits qualify under the "QMB-Only" program, some beneficiaries may be eligible for coverage of Part A and B premiums and Medicare cost-sharing, as
the QMB benefit has been imperfectly disseminated; it has been estimated that in 1991 over two million people (more than half of the elderly who were eligible for QMB) were not receiving these benefits.\footnote{194} A 1996 study estimated that approximately two-thirds of eligible beneficiaries were receiving QMB benefits.\footnote{195} As a recent Barents Group study revealed, the QMB participation rate for Medicare home health users in 1996 was slightly lower (62.4%).\footnote{196}

Moreover, even if all who qualified actually received QMB coverage, the significant number of near-poor beneficiaries would still shoulder a substantial cost-sharing burden. A 1992 study of Medicare home health beneficiaries revealed that 54.6% of single beneficiaries over sixty-five had incomes between $5000 and $15,001, while 41.3% of married users had incomes within this range.\footnote{197} The 1992 federal poverty guidelines for these cohorts were $6652 and $8509, respectively.\footnote{198} In the absence of more specific data, one can reasonably infer that a significant number of beneficiaries falling within the $5000-$15,000 income cohort would remain without QMB coverage.

More fundamentally, the difficulty with depending on either standard Medicaid coverage—which may be attained through “Medicaid estate planning”—or on coverage of Medicare cost-sharing through the QMB program is that both methods merely shift the fiscal burden of the Medicare home health benefit to the already burdened state Medicaid rolls.\footnote{199} Total Medicaid expenditures have increased at an average annual rate of change (AARC) of 12.9% since 1975, rising from $12.1 billion in 1975 to $154.4 billion in 1996.\footnote{200} Payments to aged beneficiaries rose over the same period from $4.4 billion to $36.9 billion (AARC of 10.7%).\footnote{201} Combined Medicaid expenditures on nursing home and home health care for the elderly are projected to more than double between 1993 and 2018,

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The Balanced Budget Act of 1997 affirmed that a state is not required to pay more for Medicare cost-sharing than what that state’s Medicaid program would have paid its Medicaid recipients who were ineligible for QMB. See 42 U.S.C.A. § 1396a(n) (West Supp. 1999).


\footnote{196} BARENTS GROUP LLC, supra note 193, at 60 tbl.3.

\footnote{197} See Mauser & Miller, supra note 82, at 20 tbl.1.

\footnote{198} See Gordon M. Fisher, Poverty Guidelines for 1992, SOC. SECURITY BULL., Spring 1992, at 44. Note that the latter statistic cited above ($8509) assumes a two-person family. See id.

\footnote{199} See KENNEY & MOON, supra note 32, at 20 n.11 (noting that “[s]ince Medicaid will also be under pressure to reduce spending and may even become a block-granted program, it may be undesirable to continue shifting new costs onto Medicaid”).

\footnote{200} See Medicare-Medicaid Supplement, supra note 82, at 144.

\footnote{201} See id. at 152.
increasing from $26 billion to $54.2 billion.\textsuperscript{202} States have already undertaken a variety of measures in an attempt to control these projected increases in Medicaid costs.\textsuperscript{202} However, the effectiveness of these measures is still uncertain. Given the historic political vulnerability of the Medicaid program, it may not be wise to shift additional burdens onto these state programs; states may react by reducing benefits for long-term care for the elderly, as well as for other needed programs. Ultimately, the wisdom of simply shifting costs from one federal program to another is questionable.\textsuperscript{204} One of the touted objectives of cost-sharing is to reduce the fiscal burden from the perspective of the taxpayers, not that of the administrators of a given federal program.

4. The Specified Low Income Medicare Beneficiary Program

The Specified Low Income Medicare Beneficiary Program (SLMB) also might mitigate some of the effects of cost-sharing on lower-income Medicare home health beneficiaries. Under SLMB, states must cover Medicare Part B premiums for low-income individuals whose incomes are higher than the poverty level. Thus, beneficiaries whose income is between 100\% and 120\% of the poverty line and whose assets are no greater than twice the SSI eligibility criteria may receive such assistance.\textsuperscript{205} In addition, the BBA established the “Qualified Individual” benefit within SLMB, wherein a block grant is given to the states for payment of Part B premiums. Under the first variant of the Qualified Individual program (QI-1), block grants cover individuals whose income is between 120\% and 135\% of the poverty line, whose resources do not exceed twice the SSI eligibility limit, and who are not otherwise eligible for Medicaid.\textsuperscript{206} QI-2 allows individuals whose incomes fall between 135\% and 175\% of the poverty line, whose resources are not in excess of twice the SSI limit, and

\textsuperscript{202} See Weiner, supra note 2, at 10 tbl.1-2. The figures noted above are in 1993 dollars. See id.

\textsuperscript{203} For an excellent survey of such measures, see Weiner & Stevenson, supra note 82.

\textsuperscript{204} For example, the Long-Term Care Initiative, proposed in 1999 by the Clinton Administration, includes a $1000 tax credit for beneficiaries and/or their caregivers. See Robert Pear, Clinton Seeks Aid for Care of Those with Chronic Ills, N.Y. Times, Jan. 4, 1999, at A1; Background: President Clinton’s Long-Term Care Initiative (Jan. 4, 1999) (unpublished manuscript on file with the author). Such a program might conceivably be crafted so as to reimburse beneficiaries for cost-sharing associated with Medicare home health usage. However, such an effort would merely shift the costs of home health care to general revenues, while incurring administrative costs. Moreover, the objectives of the Long-Term Care Initiative—to provide a modicum of relief to the chronically-ill and to mitigate the burden felt by caregivers—would be undercut by channeling federal funding into cost-sharing. Moreover, although their family members or caregivers might receive the tax credit, poorer beneficiaries with no tax liability would not receive any coverage under the Long-Term Care Initiative. See Background, supra, at 5.


who are not otherwise Medicaid-eligible to receive block-grant funding to pay the portion of the Part B premium that is attributable to the shift of Medicare home health benefits from Part A to Part B.207

Unfortunately, the SLMB program would prove to be of limited effectiveness in reducing the income burden associated with cost-sharing. First, although many more home health beneficiaries would be eligible for SLMB benefits than for QMB,208 they would not be exempt from cost-sharing. As was mentioned earlier, if beneficiaries were to face 20% coinsurance instituted in 1996, most home health beneficiaries would experience a cost increase of approximately $1228.209 While beneficiaries would save the not-insubstantial 1996 Part B premium of $510,210 they would still owe $1228 for home-health cost-sharing.

Limited participation by beneficiaries in the SLMB program also would reduce the program's effectiveness in protecting lower-income beneficiaries from the home-health cost-sharing burden. SLMB enrollment is even less widespread than for QMB; a 1996 study estimated that only 10% of eligible Medicare beneficiaries take advantage of the SLMB program.211 The Barents Group study found home health beneficiaries more likely to participate, though yet their participation rate was still low (25.4%).212 Unfamiliarity with public benefit programs is possibly the principal reason that the elderly do not take advantage of programs like SLMB and QMB,213 and improved outreach would undoubtedly increase participation.214 However, to significantly improve enrolment in both QMB and SLMB, HCFA and the states would need to commit more resources to public information campaigns than they have in the past.215


208 For a summary of the comparatively more stringent QMB guidelines, see supra text accompanying note 193.

209 See supra note 178 and accompanying text.

210 This figure is based on the monthly Part B premium of $42.50. See Health Care Fin. Admin., Dep't of Health and Human Servs., Medicare Cost Sharing and Premium Amounts for Supplementary Medical Insurance (Aug. 1998) (unpublished manuscript on file with the author).

211 See MOON ET AL., supra note 195.

212 See BARENTS GROUP LLC, supra note 193, at 60 tbl.3.

213 The Barents Group found that even some of the social service workers and community groups providing services to the elderly had never heard of QMB or SLMB. See BARENTS GROUP LLC, supra note 193, at 43. Another possible reason for low participation rates in these programs may be the desire to avoid the "welfare stigma" attached to Medicaid funds. See Heidi Shaner, Dual Eligible Outreach and Enrollment: A View from the States (Mar. 1999) <http://www.hcfa.gov/medicaid/o&erpt.htm>.

214 See Davis, supra note 177, at 9.

215 See, e.g., Shaner, supra note 213 (discussing state public-information campaigns and noting that they "choose materials that are not overly expensive to produce, easy to develop and revise, and uncomplicated to disseminate"). For a summary of HCFA public-information efforts to date, see HCFA Central Office Current and Previous Activities (last modified Apr. 8, 1999) <http://www.hcfa.gov/medicaid/decoact.htm>. HCFA is currently studying ways of improving its dual-eligible outreach activities. See HCFA Market Research for Medicaid: Project Description and
Moreover, the inherent complexity of the criteria associated with these programs may continue to prove a strong deterrent for some beneficiaries.\textsuperscript{216}

V. Cost-Sharing Design

The extent of the financial burden borne by Medicare home health recipients depends, to a large extent, upon the way in which cost-sharing is constructed. To conduct a comprehensive assessment of the relative merits of various cost-sharing strategies would exceed the scope of this Note.\textsuperscript{217} However, an assessment of the most salient proposals for Medicare home health reveals that some strategies are more normatively acceptable than others. Even so, vertical equity concerns remain under even the most benign cost-sharing proposal, while the gains associated with these more benign strategies may be so slight as not to justify the costs.

I consider three cost-sharing scenarios with the greatest potential normative appeal: (1) a modest copayment ($3-$5) combined with an out-of-pocket maximum;\textsuperscript{218} (2) modest coinsurance (5%-10%) combined with an out-of-pocket maximum; and (3) a low deductible. As discussed above, certain strategies—such as a 20% coinsurance rate without an out-of-pocket maximum—would unreasonably burden beneficiaries. However, the three strategies outlined above are potentially less burdensome to long-term-care recipients and high-utilizers. It is possible to calibrate either the out-of-pocket maxima posited in the first two scenarios or the deductible proposed in the third strategy so that higher-utilization beneficiaries do not incur more than, for example, $400 per year in cost-sharing. However, even $400 is a substantial sum for beneficiaries with annual incomes of, say, $10,000, beneficiaries who generally fail to qualify for QMB or Medicaid coverage.\textsuperscript{219} Moreover, limiting cost-sharing liability in this fashion also limits potential fiscal cost-savings. Indeed, when one considers the administrative costs associated with implementing such a


\textsuperscript{216} The Barents Group study found that many beneficiaries were confused about eligibility requirements. Many believed that their incomes or assets were too high or were confused about where to apply. It is therefore unsurprising that some beneficiaries do not think that the benefits of the program outweigh the time and effort costs of enrolling. See BARENTS GROUP LLC, \textit{supra} note 193, at 44.

\textsuperscript{217} For a useful discussion of cost-sharing arrangements in health care, see Rice & Morrison, \textit{supra} note 30, at 264-74. For a discussion of possible means of modifying Medicare cost-sharing, see Anderson et al., \textit{supra} note 31, at 23-24.

\textsuperscript{218} MedPAC advocates imposing a per visit copayment subject to an out-of-pocket maximum and an exemption for persons with low incomes. See 1999 MEDPAC REPORT, \textit{supra} note 22, at 94-95.

\textsuperscript{219} The 1999 poverty guideline is $8240 for an individual. See Annual Update of the HHS Poverty Guidelines, 64 Fed. Reg. 13,428, 13,428 (1999). 120% of this figure (the income level above which QMB funding is denied) is $9888.
The Price of Reform

cost-sharing program, the net benefits of cost-sharing may be exceedingly modest. Thus, the net gains from these three cost-sharing strategies are likely to be negligible, while vertical-equity considerations—albeit moderated—would persist.

Two alternative approaches to cost-sharing—exempting lower-income beneficiaries and restricting cost-sharing to home health aide services—suffer from similar defects. Tying cost-sharing to income potentially could alleviate vertical-equity problems, depending on how such a system were devised.\textsuperscript{220} However, income-related cost-sharing is susceptible to significant administrative costs and practical impediments.\textsuperscript{221} Moreover, exempting an entire income group—many of whom generate a disproportionate amount of home health costs—from cost-sharing would limit the program’s intended fiscal savings.

Alternatively, one might be tempted to apply cost-sharing only to home health aide services, in light of the particularly strong growth in that sector and the greater likelihood of substitution of informal or self care. However, long-term care beneficiaries, such as patients with cerebrovascular diseases or osteoarthritis, often require home health aide assistance for basic living tasks. Given the significant proportion of chronically ill beneficiaries who live alone, one should not be overly optimistic about their capacity to substitute informal care for home health aide services. More fundamentally, restricting home health aide services through cost-sharing places the greatest burden on the chronically ill, who rely the most on these services.

VI. Alternatives

The case for beneficiary cost-sharing proves even less compelling in light of the potential for fiscal reduction through alternative means. Existing cost-reduction strategies and additional techniques yet to be employed should be more than sufficient to contain effectively home health costs while respecting norms of vertical equity. A combination of

\textsuperscript{220} Thomas Rice and Kenneth Thorpe have passionately advocated income-related cost-sharing. See Rice & Thorpe, \textit{supra} note 106; cf. MOON, \textit{supra} note 102, at 126 (describing an income-related Part B premium). MedPAC advocates exempting lower-income persons from Medicare home-health cost-sharing. See 1999 MEDPAC REPORT, \textit{supra} note 22, at 94-95.

\textsuperscript{221} As Rice & Morrison note, the administrative problems associated with income-related cost-sharing include: (1) “determining wages or incomes for the entire population, particularly those who are not employed”; (2) “modifying the income tax system to allow for end-of-year credits or additional cost-sharing payments”, and (3) “accounting for changing personal or economic circumstances” (e.g., getting married or changing jobs). Rice & Morrison, \textit{supra} note 30, at 272. Although a “smart card” issued to lower-income beneficiaries might reduce some of these barriers, it would introduce administrative burdens of its own, in addition to privacy concerns. \textit{See id.} For further discussion of the administrative barriers to income-related cost-sharing, see Conrad & Marmor, \textit{supra} note 30, at 212-17. \textit{But see} Rice & Thorpe, \textit{supra} note 106, at 35-36 (rejecting the import of the administrative burden argument and arguing for the feasibility of income-related cost-sharing).
the following measures should be sufficient for these purposes: the IPS and eventual PPS, existing and additional anti-fraud measures, improved case-management and utilization review, better physician oversight and discharge planning, and additional clinical work in developing norms by which physicians and nurses can gauge the quality and effectiveness of home health care. Although a comprehensive discussion of each of these measures would exceed the scope of this Note, I hope to illustrate their viability and potential effectiveness.

A. IPS and PPS

While both techniques pose some risks, the IPS and PPS should be given an opportunity to demonstrate their effectiveness. The IPS is undoubtedly an inappropriate long-term strategy given the risks to chronically ill beneficiaries and the inadequate incentive structure facing providers under its cost-based reimbursement methodology. However, the IPS already seems to have moderated growth in the home health industry and is likely to continue moderating home health expansion as HCFA prepares to implement the PPS.

Although hardly free from risk, the PPS holds great potential for reducing costs without endangering health outcomes. Perhaps encouraged by some of the gains attributable to the Medicare hospital PPS, many have called for prospective payment as a means of reining in the perceived excesses in home health growth. A recent HCFA demonstration of a home health PPS based on per visit payment generated negligible cost-savings, while creating no adverse health consequences for beneficiaries. Perhaps cognizant of the risks and possibly marginal

222 See supra note 71 and accompanying text. The IPS may also hurt Medicare's vulnerable chronically ill population, as it may force agencies to reduce the frequency of visits or the level of staff who are treating the most chronically ill patients. See Study Finds Medicare Home Health Interim Payment System May Affect Most Vulnerable Patients: Beneficiaries and Providers May Face Risks Lewin Group Cautions, NAHC REP., Mar. 20, 1998, at 6.

223 See supra note 61 and accompanying text. Growth in hospital costs under the PPS rose during the 1980s, yet have declined since the early 1990s. See 1999 MedPAC REPORT, supra note 22, at 52-53 & fig.3-1. One study noted the following health effects in the wake of the hospital PPS: mortality rates following hospitalization were lower or unchanged; improvements in in-hospital processes of care that began prior to the PPS continued after its introduction; and the PPS increased the likelihood that a patient would be discharged in an unstable condition. See William H. Rogers et al., Quality of Care Before and After Implementation of the DRG-Based Prospective Payment System: A Summary of Effects, 264 JAMA 1989 (1990).


226 See Randall Brown et al., Research on Sub-Acute Care Issues, 32 HEALTH SERV. RES. 182
for cost reduction and maintenance of provider quality.

B. Reducing Fraud and Abuse

The numerous anti-fraud measures enacted in recent years and additional techniques to limit fraud and abuse should also prove effective in curbing home-health costs. In addition to the anti-fraud measures noted in Part I,\textsuperscript{232} which may already have been effective in moderating the growth of the home health benefit,\textsuperscript{233} HCFA could improve the certification process for HHAs.\textsuperscript{234} Moreover, HCFA could send beneficiaries a detailed bill outlining the services used, thereby making them more cost-conscious and helping them police provider fraud.\textsuperscript{235} Congressional establishment of clearer eligibility and coverage guidelines would also help deter spurious claims.\textsuperscript{236} While HCFA will undoubtedly incur administrative costs through some of these measures, many of these costs would be one-time expenditures associated with the initial framing of regulations and criteria. Ultimately, a mixture of supply- and demand-side measures to curb fraud holds great promise.

C. Improved Medical Oversight

Home health costs and unnecessary services could be reduced further by improving quality control and physician oversight. First, improved discharge-planning following hospital stays could reduce unnecessary referrals to HHAs.\textsuperscript{237} Second, many doctors and nurses lack effective training in geriatric care and rehabilitative medicine;\textsuperscript{238} better training in this domain would improve the capacity of medical personnel to assess the value of referrals and of continuing home health care. Third, physicians and nurses would also benefit from improved clinical work establishing guidelines by which to assess the efficacy and quality of home health care. Although some progress has been made in this area,\textsuperscript{239} considerable uncertainty and controversy exists in the medical community regarding the

\textsuperscript{232} See supra notes 9-18 and accompanying text.
\textsuperscript{233} See supra notes 16-17 and accompanying text.
\textsuperscript{234} See generally GAO CERTIFICATION, supra note 72.
\textsuperscript{235} See supra note 25 and accompanying text.
\textsuperscript{236} See 1999 MEDPAC REPORT, supra note 22, at 93.
\textsuperscript{237} For a summary of the statutory and regulatory basis for discharge-planning, see 42 U.S.C. § 1395x(ee) (1994); and 42 C.F.R. § 482.43 (1994). See also MEDICARE COVERAGE AND APPEALS, supra note 51, at 13 & n.53; Alfred J. Chipkin, Jr., Medicare Discharge-Planning Regulations: An Advocacy Tool for Beneficiaries, 29 CLEARINGHOUSE REV. 152 (1995).
\textsuperscript{238} See Bogardus Interview, supra note 129.
\textsuperscript{239} See Kane et al., supra note 131; Peter W. Shaughnessy et al., Measuring and Assuring the Quality of Home Health Care, HEALTH CARE FIN. REV., Fall 1994, at 35.
benefits of a per visit method, however, HHS has proposed a per episode basis for the home health PPS. Indeed, under a recent HCFA per episode PPS demonstration for home health, per episode costs were reduced by 13%, utilization by 17%, and average length of stay by 15%. Of course, much depends on the payment rates and conditions ultimately imposed by HCFA. Developing appropriate rates for the diverse home health beneficiary and provider populations has indeed proven to be a formidable task. However, despite these challenges, the PPS offers hope

397 (1997). But see Christine E. Bishop et al., The Home Health Visit: An Appropriate Unit for Medicare Payment?, HEALTH AFF., Winter 1996, at 145, 148 (questioning the per visit method and noting that home health aide visits were much shorter under HCFA’s per visit PPS demonstration); Barbara R. Phillips et al., Do Preset Per Visit Payment Rates Affect Home Health Agency Behavior?, HEALTH CARE FINANCING REV., Fall 1994, at 91, 91 (finding “no compelling evidence of any impact on cost per visit, volume of home health services, agency revenue and profit, patient selection and retention, quality of care, or use and cost of Medicare services”). For a good summary of the findings of the HCFA demonstration project, see Medicare Program: Prospective Payment System for Home Health Agencies, 64 Fed. Reg. 58,134, 58,137-38 (1999) [hereinafter Medicare Program].

227 Under the per visit method, agencies have an incentive to reduce average cost per visit and to increase the number of visits they provide. Some agency strategies, such as reducing overhead or wages, would not affect the content of home health visits. However, HHAs also might choose to spread treatment out over the course of more visits to maximize Medicare payment. See Bishop et al., supra note 226, at 146-47. There might also be a bias in favor of patients requiring numerous visits, as opposed to sporadic, skill-intensive interventions. Such a bias generally would not be adverse to the interests of the chronically ill, yet might put those with more acute needs at greater risk.

228 See Medicare Program, 64 Fed. Reg. at 58,208. Under the proposed rule, HCFA would employ a 60-day episode as the basic unit of payment to providers. An individual would be covered for 60 days of care regardless of the number of days of care actually provided during the 60-day period, subject to certain exceptions.

229 See Shalala Reports, supra note 24. For further discussion of the HCFA per episode demonstration, see Medicare Program, 64 Fed. Reg. at 58,138-40. The significant results obtainable under a per episode PPS thus further undermine MedPAC’s suggestion that Congress authorize per visit copayments as a complement to the PPS. See supra note 25. If a per episode PPS is capable of achieving the kind of cost reductions indicated above, then the further addition of copayments is unnecessary and potentially harmful, in light of the equity considerations discussed in preceding sections.

In contrast with the 60-day unit recently proposed by HCFA, the per episode demonstration project limited treatment episodes to periods of 120 days or less. See KENNEY & MOON, supra note 32, at 15. Under the recently proposed PPS, there is no limit to the number of episodes a given beneficiary may experience. As long as the patient obtains, inter alia, a physician certification upon the expiration of each 60-day period, coverage continues. See Telephone Interview with Sally Kaplan, Medicare Payment Commission (MedPAC) (Dec. 21, 1999). Thus, the PPS would not limit access to care by long-term care users, who experience home health episodes in excess of 60 days, an outcome that comports with considerations of vertical equity.

230 The data from the Outcomes and Assessment Information Set (OASIS), which HCFA is in the process of compiling, will serve as the basis for the prospective payment rates ultimately set by HCFA. In addition to facilitating case-mix adjustment, OASIS will also provide valuable standards by which HCFA can assess quality of care and outcomes. See Medicare and Medicaid Programs: Use of the OASIS as Part of the Conditions of Participation for Home Health Agencies, 62 Fed. Reg. 11,035, 11,036 (1997). For a discussion of HCFA’s progress thus far in developing case-mix adjustment parameters, see Medicare Program, 64 Fed. Reg. at 58,140-42, 58,172-86.

In January 1999, the NAHC expressed concern that hasty development and implementation of the PPS would limit the industry’s opportunities for involvement and would affect negatively the PPS’s ultimate form. See Shalala Reports, supra note 24. It remains to be seen whether HCFA’s recent efforts will prove sufficient to allay industry fears.

231 For a discussion of the difficulties in developing the appropriate “case-mix,” see supra
efficacy of home health care. Fourth, Congress should consider requiring an independent assessment of need for beneficiaries receiving extensive home health care.

D. Utilization Review and Case Management

Finally, some form of enhanced utilization review and case-management procedures could be developed for Medicare home health beneficiaries. The claims review process conducted by Medicare intermediaries approximates a kind of utilization review, yet is underfunded and sporadic. HCFA should encourage intermediaries to conduct more vigilant claim reviews and give them more funding to make such assessments. Moreover, HCFA could require that providers take a more active role in conducting internal utilization reviews. The pressure exerted by the PPS on HHAs to reduce costs would provide a further incentive for HHAs to assist in this process. Finally, the third-party assessment of need, discussed above, might be folded into a broader utilization review.

Case management, which has been employed by the states in their administration of Medicaid benefits, including home health, could also be attempted in Medicare. Such an effort would require that case managers take into account the unique health needs of beneficiaries, while remaining cognizant of cost considerations. Case managers could aid in discharge planning in the post-acute setting, assessing the relative merits of SNF, home health care, and other treatment. Managers could also conduct an examination of the needs and usage of high-utilizer and long-term care cohorts within the home health population. However, HCFA would need to make certain that the reduction in Medicare expenditures and improved

240 See supra notes 127-31 and accompanying text.
241 See 1999 MEDPAC REPORT, supra note 22, at 94. Whereas doctors and nurses may face incentives to over-prescribe services under the IPS, providers under an episode-based PPS would have an incentive to stint on care. Although not free from practical difficulties and cost considerations, an independent assessment would address the problems associated with these incentive structures. See id.
242 For a discussion of utilization review techniques in the private sector, see Mark J. Schlesinger et al., Medical Professionalism Under Managed Care: The Pros and Cons of Utilization Review, HEALTH AFF., Jan.-Feb. 1997, at 106.
243 See supra note 70 and accompanying text.
244 Case management has been defined by the Commission for Case Manager Certification as "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes." CCM CERTIFICATION GUIDE: CERTIFIED CASE MANAGER (1992).
efficacy of treatment justify the administrative costs associated with utilization-review and case-management techniques. Ultimately, effective case-management and utilization-review techniques would also require enhanced clarity regarding the efficacy and appropriateness of home health services.

Conclusion

The Medicare home health benefit is a singularly poor candidate for beneficiary cost-sharing. The difficulty of determining when home health care is medically “necessary,” in addition to the inherent bluntness of cost-sharing as an instrument for deterring frivolous usage, undermines the case for home-health cost-sharing. More fundamentally, the vulnerability of the target population presents significant vertical equity concerns. The availability of Medigap policies, Medicaid, and programs such as QMB and SLMB fails to mitigate these concerns. Moreover, while the more benign variants of cost-sharing may present less pressing vertical equity concerns, they would not reap sufficient reductions in Medicare expenditures to justify the administrative costs and other difficulties inherent in their construction. My analysis of the numerous alternative measures available for containing home health costs—PPS, improved oversight, and utilization-review techniques—underscores the need for more creative solutions to the home health problem. The traditional reliance upon beneficiary cost-sharing in public insurance programs must yield to an openness to alternatives.
Appendix

Figure 1. Medicare Home Health Agency Program Payments, 1974-1996.

Figure 2. Medicare Home Health Expenditure Growth Rates.

Figure 3. Distribution of Medicare-Certified Home Health Agencies, 1980-1995.

Figure 4. Trends in the Six Most Frequent Medicare Home Health Agency Diagnoses, 1987-1996.

Note: Diagnoses correspond with the following ICD-9-CM codes: 250: diabetes mellitus; 428: heart failure; 401: essential hypertension; 715: osteoarthrosis; 436: acute cerebrovascular disease; and 496: chronic airway obstruction.

Figure 5. Responsiveness of the Demand for Medical Care with No Insurance ($D_n$), 50% Copayment ($D_{50}$), and 20% Copayment ($D_{20}$).

Figure 6. Percent of Medicare Home Health Users and Non-Home Health Users with Selected Characteristics, 1994.

Figure 7. Distribution of Medicare Home Health Users and Expenditures, 1994.

Source: JOEL LEON ET AL., HENRY J. KAISER FAMILY FOUND., UNDERSTANDING THE GROWTH IN MEDICARE’S HOME HEALTH EXPENDITURES 17 fig.7 (1997).
Figure 8. Percent of Medicare Home Health Users with Selected Characteristics (Comparison of "High Utilizers" and Average Home Health Users).

Source: JOEL LEON ET AL., HENRY J. KAISER FAMILY FOUND., UNDERSTANDING THE GROWTH IN MEDICARE'S HOME HEALTH EXPENDITURES 21 fig.10 (1997).