

OPPOSE COPAYMENTS FOR MEDICARE HOME HEALTH SERVICES

ISSUE: Copayments have been advanced in Congress as a means of deficit reduction as well as a means of limiting the growth of Medicare home health expenditures. Congress should oppose a copayment for the home health benefit.

RATIONALE:

A copayment would create a significant barrier for those in need of home care and lead to increased use of more costly institutional care.

- Congress modernized the home health benefit by eliminating copays in 1972 and a home health care deductible in 1980 to encourage use of less costly, noninstitutional services. The Urban Institute's Health Policy Center concluded that copays "...would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays." ("A Preliminary Examination of Key Differences in the Medicare Savings Bills," 7/13/97.)
- Since implementation of the home health care prospective payment system, there have been substantial declines in use of home health care, increases in use of more expensive skilled nursing facilities (SNFs) and other post acute providers, and some substitution of SNFs for home health services following hospital discharges. (MedPAC Report, June 2003.) A home health copay would worsen this trend.

Copayments are an inefficient and regressive "sick tax" that would fall most heavily on the poorest and oldest Medicare beneficiaries.

- About 70% of home health users are age 75 or older. More than half of all users are women and more than half have family incomes of \$15,000 a year or less. About 43% of home health users have limitations in one or more activities of daily living, compared with 9% of beneficiaries in general. (AARP, "Home Health Copayment Would Have Negative Consequences for Medicare Beneficiaries," 8/7/98.)
- The Commonwealth Fund cautioned lawmakers that cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs. ("One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," 9/01). The elderly already spend 22% of their income on health care; those in poor health spend 44% and those who are low-income women over 85 spend 52%. ("Medicare's Future: Current Picture, Trends and Prescription Drug Policy Debate," Updated Charts, Commonwealth Fund, 7/1/03.) Seniors spend nearly twice as much of their income on their health care now than they did before Medicare began. (AARP, "Out of Pocket Health Spending by Medicare Beneficiaries Ages 65 and Older: 1997 Projections," 12/1/97.)
- Even if Medicaid recipients with incomes below 135% of the poverty level were exempted from the home health copay, a large percentage of those with incomes below this level

would be ineligible for protection from the home health copay because of the restrictive asset limitation, which has not been adjusted since 1989 and serves as a major barrier. (The Commonwealth Fund, "The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs," October 2002.)

Home care patients and their families already contribute to the cost of their home care.

- Elderly Medicare patients receiving the home health benefit pay about 30% of their home care expenses out-of-pocket. ("Doing Without: The Sacrifices Families Make to Provide Home Care," Families USA, 7/94, p. 17)
- Patients going on service for home health must pay a 20% copay and the Part B deductible to retain the services of a physician who can order the home health plan of care and provide care plan oversight. They must pay a copay for home medical equipment. Many home health patients will also incur the hospital deductible and copays and the skilled nursing facility copays before becoming eligible for the home health benefit. The Commonwealth Fund estimated that the average Medicare beneficiary in 2000 spent \$1,470 for Medicare premiums and cost sharing exclusive of home health.
- With hospital and nursing home care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out of pocket by patients without family support. Family members are frequently trained to render semi-skilled support services for home care patients, which Medicare would have to pay for in the hospital or nursing home setting.

Copayments as a means of reducing utilization would be particularly inappropriate for home health care.

- The number of Medicare beneficiaries receiving home health care annually has dropped by 1.3 million since 1997 and the average number of visits provided over a 60-day episode has dropped from 36 to 20.
- According to MedPAC, in the first full year of PPS, 300,000 fewer Medicare beneficiaries found access to home health services. This represents a 12 percent decline in the number of Medicare home health users in just one year. The reduction in the number of Medicare users precedes the payment rate cut of October 1, 2002, the loss of the 10 percent rural add-on, and pending post-payment adjustments (such as partial episode payment reductions or adjustments due to downcoding by the intermediaries).

Imposition of home health copayments should not be used for deficit reduction or to pay for other initiatives.

- The Balanced Budget Act of 1997 intended to reduce projected spending on home health services by \$16 billion over five years. Instead, home health outlays were reduced by \$74 billion.
- Since 1997, home health spending has dropped by nearly half and CMS estimates of future growth have dropped dramatically.

Medigap coverage would not necessarily cover home health copays and would be too costly for most home care recipients.

- Thirty-seven percent of Medicare recipients have no private supplemental insurance. (Congressional Research Service, "Medicare: The Role of Supplemental Health Insurance," 10/10/94, p. 2) The law governing Medigap policies does not require that all models cover copays; in fact some in Congress have proposed that Medigap insurers be prohibited from covering certain copays.

Copayments would impose an unfunded mandate on the states.

- About 25% of all home care users, and 45% of long stay home care users (over 200 visits), are Medicaid-eligible. (Mauser and Miller, "A Profile of Home Care Users in 1992," Health Care Financing Review, Vol 160, Fall 1994, p. 20.)
- Even if Medicaid recipients with incomes below 135% of the poverty level were exempted, a home health copay would cause more Medicare recipients to "spend down" to become eligible for Medicaid under the "medically needy" program.

Copayments would be another federal administrative burden on providers and would increase Medicare costs.

- Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and rebill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care.
- Nurses and home care aides might be placed in the position of having to collect copays, a task for which they are unsuited. They would have to carry large sums of money, increasing their exposure to robbery and muggings. Collecting copays in a person's home is not like a hospital or physician's office where clerical staff can handle billing and collection.

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