

August 6, 2003

The Honorable Charles Grassley  
U.S. Senate  
Washington, D.C. 20510

Dear Senator Grassley:

On behalf of the following organizations, we are writing to urge you to oppose new copayments for Medicare home health users in the Medicare conference bill. The proposal was included only in the House Ways and Means Committee bill, but was rejected in both the Senate and House Energy and Commerce Committee proposals.

Home health copayments are an inefficient and regressive “sick tax” that would harm our nation’s poorest, most vulnerable beneficiaries. The Urban Institute concluded that copayments “...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.”<sup>1</sup> The average user is 78 years old, and an estimated 87% are women, most of whom live alone. According to the Kaiser Family Foundation, 70% of these individuals have annual incomes less than \$15,000. About 43% of home health users have limitations in one or more activities of daily living, compared with 9% of Medicare beneficiaries in general.<sup>2</sup>

The average senior spends 22% of his/her income on health care. Those in poor health spend 44% and low-income women over 85 spend 52%.<sup>3</sup> Patients using Medicare home health must already pay the Part B deductible and a 20% coinsurance for a physician to prescribe and oversee the home health plan of care; 20% coinsurance for home medical equipment; and, for those coming from a hospital or skilled nursing facility (SNF), the Part A deductible and SNF coinsurance. In addition, many users also pay for personal assistance with activities of daily living, respite care, and other non-covered services to remain independent. A \$40 per episode copayment would impose a significant additional burden on many beneficiaries who can least afford it and would create a slippery slope to even higher copayments in the future.

Another reason why the copayment would not be affordable for many is because the low-income protections in the proposal are inadequate, largely because they include a burdensome asset test, which has not been adjusted since 1989 and serves as a major barrier to receiving protection. According to The Commonwealth Fund, 32% of beneficiaries with incomes below poverty, and over half of those with income between 100% and 120% of poverty, would not be eligible for help because of the asset test.<sup>4</sup> In addition, millions of beneficiaries eligible for low-income protections do not enroll because of inadequate outreach or a burdensome application process.

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<sup>1</sup> Urban Institute Health Policy Center, “A Preliminary Examination of Key Differences in the Medicare Savings Bills,” 7/13/97.

<sup>2</sup> AARP, “Home Health Copayment Would Have Negative Consequences for Medicare Beneficiaries,” 8/7/98.

<sup>3</sup> The Commonwealth Fund, “Medicare’s Future: Current Picture, Trends and Prescription Drug Policy Debate,” Updated Charts, 7/1/03.

<sup>4</sup> The Commonwealth Fund, “The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs,” October 2002.

We believe that younger disabled beneficiaries would be disproportionately harmed by a copayment, since they tend to be more likely to need home health services compared with aged beneficiaries, on average. Because of the nature of their disability, younger beneficiaries also use the benefits for extended periods of time and, therefore, would be subject to continuous copayments.

A new home health copayment would force more beneficiaries into nursing homes prematurely. According to the June 2002 MedPAC report, there have been recent substantial recent declines in the use of home health care, accompanying increases in use of more expensive skilled nursing facilities (SNFs), and substitution of SNFs for home health services following hospital discharges. A copayment would exacerbate this penny-wise, pound-foolish trend. For similar reasons, there is a growing bipartisan consensus for eliminating coinsurance for preventive benefits.

Cost sharing as a means of reducing utilization would be particularly inappropriate for home health care. The number of Medicare beneficiaries receiving home health care 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.

The copayment would shift costs onto Medicaid at a time when states are experiencing significant budget shortfalls under the program. Lower income beneficiaries who could not afford the new Medicare copayment would likely have to rely more on Medicaid home and community-based programs, which currently have large waiting lists in many states. In addition, the new copayment would force these frail, lower income beneficiaries to spend-down onto Medicaid more quickly.

Nurses and home care aides might be placed in the position of having to collect copayments, a task for which they are unsuited. Collecting copayments in a person's home is not like a hospital or physician's office where clerical staff can handle billing and collection. In addition, unlike hospitals, there is no provision for bad debt from uncollected copayments currently built into the base payment for home health care.

It would be unwise and inhumane to apply a new copayment to the sickest, most vulnerable beneficiaries who can least afford it. Congress wisely eliminated the Medicare home health copayment 30 years ago for the very reasons that it should not be resurrected now. The home health copayment in the 1960s and early 1970s deterred Medicare beneficiaries from accessing home health care and instead created an incentive for more expensive institutional care. Reinstating the copayment today would directly conflict with the goal of Congress to modernize the Medicare program.

We strongly urge you to reject any new home health copayment. Thank you for considering our request.

*Advancing Independence*

*Alzheimer's Association*

*American Association for Homecare*

*American Association for International Aging*

*American Association of Homes and Services for the Aging*

*American Federation of Teachers Program on Retirement and Retirees*

*American Geriatric Society*

*American Network of Community Options and Resources (ANCOR)*  
*American Society of Consultant Pharmacists*  
*Association for Gerontology and Human Development in  
Historically Black Colleges and Universities*  
*B'nai B'rith International*  
*Catholic Health Association*  
*Center for Medicare Advocacy*  
*Easter Seals*  
*Families USA*  
*Family Voices*  
*Gray Panthers*  
*International Union, UAW*  
*Lutheran Services in America*  
*Meals on Wheels Association of America*  
*National Academy of Elder Law Attorneys*  
*National Adult Day Services Association*  
*National Association for Home Care and Hospice*  
*National Association of County Behavioral Health Directors*  
*National Association of Developmental Disabilities Councils*  
*National Association of Professional Geriatric Care Managers*  
*National Association of Retired and Senior Volunteer Program Directors*  
*National Association of Senior Companion Project Directors*  
*National Caucus and Center on Black Aged*  
*National Council on the Aging*  
*National Multiple Sclerosis Society*  
*National Respite Coalition*  
*National Senior Citizens' Law Center*  
*Older Women's League (OWL)*  
*Paralyzed Veterans of America*  
*The Arc of the United States*  
*United Cerebral Palsy*  
*United Jewish Communities*  
*Visiting Nurse Associations of America*  
*Volunteers of America*