

**NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE (NAHC)
VISITING NURSE ASSOCIATIONS OF AMERICA (VNAA)**

LOBBY DAY, JUNE 12, 2003

**OPPOSE COPAYMENTS AND OTHER COST-SHARING FOR
MEDICARE HOME HEALTH SERVICES**

ISSUE: Copayments and other cost-sharing 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 any copayment or other cost sharing proposal 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)
- **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). Seniors spend nearly twice as much of their income on their health care now than they did before Medicare began (10.6% in 1961 as compared to 21% in 1997). (AARP, "Out of Pocket Health Spending by Medicare Beneficiaries Ages 65 and Older: 1997 Projections," 12/1/97)
- **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, 7/04, p. 17) Home health patients also must pay a copay for physician services in preparing a home health plan of care and for home medical equipment. 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.

- **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 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.
- **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 \$72 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, making it highly likely that states would be required to meet their copay liability. (Mauser and Miller, "A Profile of Home Care Users in 1992," Health Care Financing Review, Vol 160, Fall 1994, p. 20)
- **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.