DEFEAT THE "SICK TAX"—OPPOSE EFFORTS TO IMPOSE A FEE TO BE PAID BY PATIENTS TO ACCESS MEDICARE HOME HEALTH SERVICES

ISSUE: Copayments for Medicare home health services 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. Some Medicare Advantage (MA) plans have imposed home health copays. Copays are regressive, inefficient and fall most heavily on the poorest and oldest Medicare beneficiaries.

The National Commission on Fiscal Responsibility and Reform (2010) recommended a uniform 20 percent copay and a uniform overall deductible of $550 for all Medicare services combined, including home health care. In January 2011 the Medicare Payment Advisory Commission (MedPAC) voted to recommend a home health copay (as much as $150 per episode) for episodes not preceded by a hospital or nursing home stay as a means to encourage beneficiaries to control utilization of care.

RECOMMENDATION: Congress should oppose any copay or deductible proposal for Medicare home health services and should prohibit Medicare Advantage plans from charging a home health copay or deductible.

RATIONALE: Home health cost sharing 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.)
- A study published in the New England Journal of Medicine ("Increased Ambulatory Care Copayments and Hospitalizations among the Elderly," January 2010) found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations. It concluded that raising cost sharing for ambulatory care among elderly patients may have adverse health consequences and increase total spending on health care. The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay.

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

- About 86 percent of home health users are age 65 or older – 70 percent age 75 or older. More than 60 percent of all users are women. Home health users are poorer on average than the Medicare population as a whole. 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).
- Even if Medicaid recipients with low incomes were exempted from the home health copay, a large percentage of low

income beneficiaries 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.

- According to the AARP Public Policy institute ("Medicare Beneficiaries' Out-of-Pocket Spending for Health Care Services, June 2009"), Medicare beneficiaries spent an average of $4,394, or 37 percent of the individual beneficiary's income, on health care costs. The oldest and poorest beneficiaries spent more than half their incomes on health care services.
- Patients going on service for home health must pay a 20 percent 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.
- 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.

- Since 1997, the average number of home health visits provided over a 60-day episode under Medicare has dropped from 36 to 18. Spending on a per patient basis is no greater today than in 1997. Adjusted for inflation, Medicare spends billions less on home health care today than in 1997 and serves fewer Medicare beneficiaries. The home health benefit has dropped from 8.7 percent of the Medicare program to 3.7 percent, and CMS projects that it will drop to 3.5 percent by 2020.

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 more than $74 billion over the same time period and Medicare spending on skilled nursing facility care increased dramatically.
- Since 1997, Medicare spending on home health care has consistently been billions below CBO projections.

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

- Although 17 percent of Medicare beneficiaries purchase Medigap coverage and 34 percent have coverage from an employer sponsored plan, there is no assurance that these plans will cover a home health copay. (Kaiser Family Foundation, 2009) The law governing Medigap policies does not require that all models cover copays. Likewise, the 22 percent enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.

Copayments would impose an unfunded mandate on the states.

- About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 30 percent by MedPAC) of Medicare home health beneficiaries—who are some of the oldest, sickest, and poorest beneficiaries—are eligible for Medicaid. (e.g. Mauser and Miller, "A Profile of Home Care Users in 1992," Health Care Financing Review, Vol. 160, Fall 1994, p. 20.) A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs.
- Even if Medicaid recipients with low incomes 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 re-bill. 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.