

## Medicare Home Health Copayments: Harmful for Beneficiaries

### Background:

Some policymakers have suggested adding copayments for Medicare home health services as a means of both reducing the deficit and limiting the growth of Medicare home health expenditures. Some Medicare Advantage (MA) plans have already imposed home health copayments.

### Our Position:

Congress should oppose any copayment proposal for Medicare home health services. Congress eliminated the home health copayment in 1972 for the very reasons that it should not be resurrected now—deterring care at home and creating incentives for more expensive institutional care.<sup>i</sup> Congress should also oppose any proposal to cap payments for episodes of care that would reduce beneficiary access or otherwise restrict the number of home health visits to which beneficiaries are entitled.<sup>ii</sup> LCAO recognizes the need to reduce health care spending over the long term. With respect to Medicare, we support savings mechanisms that address system wide health care inflation and build on the cost savings and efficiencies of the Affordable Care Act. Proposals that shift costs onto beneficiaries, like adding copayments to home health services, fail to meet these standards.

### Our Rationale:

**Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute’s Health Policy Center found that home health 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.”<sup>iii</sup> Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.<sup>iv</sup> The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copayment. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, “may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long term.”<sup>v</sup> According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by \$6-13 billion over ten years.<sup>vi</sup>

**Copayments are an inefficient and regressive “sick tax” that would fall most heavily on the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.<sup>vii</sup> Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.<sup>viii</sup> The Commonwealth Fund cautioned 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.”<sup>ix</sup>

**Most people with Medicare cannot afford to pay more.** In 2014, half of Medicare beneficiaries—more than 25 million seniors and people with disabilities—lived on incomes below \$24,150.<sup>x</sup> On average, Medicare households already spend 14 percent of their income on health care costs, about three times as much as non-Medicare households.<sup>xi</sup>

**Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty (in 2015, about \$12,000 per year for an individual and \$16,200 for a couple) and non-housing assets below just

\$7,280 for an individual and \$10,930 for a couple. Even among Medicare beneficiaries eligible for QMB protection, only about one-third are actually enrolled in the program.<sup>xii</sup>

**Individuals receiving home care and their families already contribute to the cost of their home care.** . With hospital and skilled nursing facility 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 individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated \$470 billion a year in unpaid care to their loved ones, and too frequently having to cut their work hours or quit their jobs.<sup>xiii</sup>

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

Beneficiaries do not “order” home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is scant evidence of overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 3 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.<sup>xiv</sup>

**Home health copayments would shift costs on to states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by MedPAC) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.

**Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copayment and, in 2010, only 23 percent of Medicare beneficiaries have Medigap coverage. For the 26 percent of Medicare beneficiaries who currently have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage.<sup>xv</sup> In 2015, 31 percent of beneficiaries 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.<sup>xvi</sup>

**Copayments would impose costly administrative burdens and 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.

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<sup>i</sup> *Congressional Record*, October 5, 1972, p. 33939.

<sup>ii</sup> Similarly, Congress removed a 100 visit limit on home health care services in the Omnibus Budget Reconciliation Act (OBRA) of 1980. See forthcoming LCAO document opposing episode payment caps.

<sup>iii</sup> Urban Institute Health Policy Center, “A Preliminary Examination of Key Differences in Medicare Savings Bills,” July 13, 1997.

<sup>iv</sup> Trivedi, Amal N., Husein Moloo and Vincent Mor, “Increased Ambulatory Copayments and Hospitalizations among the Elderly,” *New England Journal of Medicine*, January 2010.

<sup>v</sup> National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, “Medicare Supplemental Insurance First Dollar Coverage and Cost Shares Discussion Paper” (October 2011).

<sup>vi</sup> Avalere Health LLC, “Potential Impact of a Home Health Co-Payment on Other Medicare Spending,” July 12, 2011.

<sup>vii</sup> CMS Office of Information Services, Medicare & Medicaid Research Review/2011 Supplement, Table 7.2.

<sup>viii</sup> Avalere Health LLC, “A Home Health Copayment: Affected Beneficiaries and Potential Impacts,” July 13, 2011.

<sup>ix</sup> The Commonwealth fund, “One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems,” September 2001.

<sup>x</sup> Kaiser Family Foundation, “Income and Assets of Medicare Beneficiaries, 2014 and 2030” (2015)

<sup>xi</sup> Kaiser Family Foundation, “Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households,” (2014)

<sup>xii</sup> Government Accountability Office, “Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment,” GAO-12-871 (September 2012)

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<sup>xiii</sup> *Family Caregivers Provide Staggering \$470 Billion in Unpaid Care According to AARP Study*, AARP (July 16, 2015), <http://www.aarp.org/about-aarp/press-center/info-07-2015/family-caregivers-provide-470-billion-in-unpaid-care-aarp-study.html>

<sup>xiv</sup> <http://kff.org/report-section/a-primer-on-medicare-how-much-does-medicare-spend/>

Kaiser Family Foundation, “A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers,” (2015)

<sup>xv</sup> Kaiser Family Foundation, “Medigap Reform: Setting the Context for Understanding Recent Proposals,” (2013)

<sup>xvi</sup> Kaiser Family Foundation, “Medicare Advantage,” (2015)