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**STATEMENT SUBMITTED BY THE  
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE  
TO THE  
HOUSE WAYS AND MEANS COMMITTEE  
AUGUST 14, 2013**

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

NAHC appreciates this opportunity to provide our views on draft legislation that would restructure beneficiary cost sharing within Medicare. The draft legislation includes a provision that would impose copayments for Medicare home health services.

Congress eliminated the home health copayment in 1972 for the very reasons it should not be resurrected now. The home health copayment in the 1960s and 1970s deterred Medicare beneficiaries from accessing home health care and instead created an incentive for more expensive institutional care. Reinstating the home health copay today would undo the progress made in efforts to reduce unnecessary hospitalizations and nursing home stays.

Moreover, home health services already have the highest cost-sharing in Medicare. On a daily basis, millions of spouses, family, friends, and community groups contribute the equivalent of billions of dollars worth of care and support to keep their loved ones at home. Further, care in the home means that the Medicare beneficiary provides all the financial support in terms of room and board that are otherwise paid for by Medicare and Medicaid in an institutional setting.

Numerous studies have concluded that a copay can discourage use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings. We respectfully submit that Congress should oppose any copay proposal for Medicare home health services.

Proposals to impose a home health copay should be rejected for the following reasons:

- **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>i</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>ii</sup> The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay. Studies have shown that Medicaid copays can backfire with beneficiaries avoiding care leading to higher Medicaid overall costs.<sup>iii</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>iv</sup>
- **The burden of a home health copayment would disproportionately impact 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>v</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>vi</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>vii</sup>
- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries—about 25 million seniors and people with disabilities—lived on incomes below \$22,000, just under 200 percent of the federal poverty level.<sup>viii</sup> Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.<sup>ix</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 percent of poverty (\$11,412 for singles, \$15,372 for couples) and non-housing assets below just \$6,940 for singles and \$10,410 for couples. In sharp contrast, eligibility for cost sharing assistance for individuals under age 65 is set at 138 percent of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.<sup>x</sup>

- **Individuals receiving home care and their families already contribute to the cost of their home care.** 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 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 \$450 billion a year in unpaid care to their loved ones,<sup>xi</sup> and too frequently having to cut their work hours or quit their jobs.
- **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 no evidence of systemic 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 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.<sup>xii</sup>
- **Home health copayments would shift costs to the states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by the Medicare Payment Advisory Commission (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 copay and only 17 percent of Medicare beneficiaries have Medigap coverage. For the 34 percent of Medicare beneficiaries who 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>xiii</sup> Likewise, the 25 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.
- **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. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care. Home health agencies cannot absorb these costs as nearly 50 percent of home health agencies are projected to be paid less than their costs by Medicare. Overall home health agency margins from a combination of Medicare, Medicaid, Medicare Advantage and other payment sources average less than zero.<sup>xiv</sup>

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- <sup>i</sup> Urban Institute Health Policy Center, “A Preliminary Examination of Key Differences in Medicare Savings Bills,” July 13, 1997.
- <sup>ii</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>iii</sup> Leighton Ku and Victoria Wachino, “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Findings,” Center on Budget Priorities (July 7, 2005).
- <sup>iv</sup> Avalere Health LLC, “Potential Impact of a Home Health Co-Payment on Other Medicare Spending,” July 12, 2011.
- <sup>v</sup> CMS Office of Information Services, Medicare & Medicaid Research Review/2011 Supplement, Table 7.2.
- <sup>vi</sup> Avalere Health LLC, “A Home Health Copayment: Affected Beneficiaries and Potential Impacts,” July 13, 2011.
- <sup>vii</sup> The Commonwealth fund, “One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems,” September 2001.
- <sup>viii</sup> “Medicare at a Glance,” Kaiser Family Foundation, November 2011.
- <sup>ix</sup> “Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare households”—Kaiser Family Foundation.
- <sup>x</sup> “Government Accountability Office, “Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment,” GAO-12-871 (September 2012).
- <sup>xi</sup> L. Feinberg, S.C. Reinhard, A. Houser, and R. Choula, “Valuing the Invaluable: 2011 Update, the Growing Contributions and Costs of Family Caregiving,” AARP Public Policy Institute Insight on the Issues 51 (Washington, DC: AARP, June 2011).
- <sup>xii</sup> CMS Research, Statistics, Data, and Systems/Statistics, Trends and Reports, Medicare Medicaid Stat Supp/2011 (Tables 3.1 and 7.1).
- <sup>xiii</sup> Kaiser Family Foundation, “Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007,” August 2009.
- <sup>xiv</sup> National Association for Home Care & Hospice (NAHC) Cost Report Data Compendium, Updated 2012.