Impact of Home Health Co-payments – Facts and Figures

Background: Numerous proposals have been made as part of deficit reduction discussions to institute co-payments for Medicare beneficiaries who receive Medicare-covered home care. President Obama’s fiscal year 2013 proposed budget includes a provision that would charge a $100 co-payment for new home health users per episode of care (starting in 2017). This co-payment would apply for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay.

HCA strongly opposes any Medicare home health co-payment for the following reasons:

• A home health co-payment imposes a significant financial burden on sick, frail and vulnerable populations. In fact, 83% of Medicare Part B home health users who are not dually eligible do not have supplemental coverage and would have to pay the full co-payment out of pocket. Nearly 60% of these home health users have incomes below 200% of the poverty line.¹

• The typical home health patient is elderly, with 34.7% of patients being between the ages of 75 and 84 and 29.1% being over age 85.² Approximately 63% of patients are women, a population, in home care, which is disproportionately low income; for those who are 65 and older, almost 20% had income below 125% of the official federal poverty level in 2008, including 34% of African-American and Hispanic older women. The figures are even higher for women age 75 and older. Many do not qualify for Medicaid coverage and cannot afford home health co-payments.³

• Medicare Part B home health users without supplemental coverage are sicker, more likely to have severe disabilities, and more likely to live alone than other Medicare beneficiaries:⁴
  
  o 87% of home health users who would pay the co-payment out of pocket have three or more chronic conditions; 38% live alone.

  o 23% have disabilities severe enough to qualify for a nursing home level of care.

• Studies show that increasing co-payments can lead to higher inpatient costs that offset any decrease in the utilization of other services (such as outpatient visits).⁵

  o A review of nearly 900,000 Medicare Advantage enrollees in 172 plans found that raising co-payments for outpatient care led to increased use of inpatient hospital services with adverse health consequences and increased overall spending. In fact, plans that raised outpatient co-payments had 2.2% more annual hospital admissions and 13.4% more inpatient days per 100 enrollees.⁶

  o When retirees’ cost-sharing for physician and prescription drugs was increased, the retirees reduced the dollars spent on these services, but they used more inpatient care.⁷

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• An increase in prescription drug cost-sharing led to increased usage of emergency rooms and inpatient services.  

• Home health services are very cost effective, even when compared to other post-acute services. Any reduction in cost-effective home health services, stemming from a beneficiary co-payment, would reduce the cost-saving capacity of home health providers who serve patients in the least restrictive setting:
  - Medicare Part A spending after the initial hospitalization for patients with diabetes, chronic obstructive pulmonary disease, or congestive heart failure who received home health services in the same quarter as the initial hospitalization was lower than Part A spending for similar patients who received other post-acute services in that initial quarter. If the beneficiaries who received other post-acute services after the initial hospitalization had used home health instead, Medicare Part A spending over the 2006 to 2009 period could have been reduced by $2.07 billion.

  - Home health use after an initial hospital visit is associated with an estimated 20,426 fewer hospital readmissions. Avoiding these readmissions saved Medicare an estimated $670 million from 2006 to 2009.

• A home health co-payment will increase Medicaid costs and lead to unintended and undesirable consequences:
  - In New York State, the proposed co-payment would likely shift costs from Medicare to Medicaid, as Medicaid would pay the co-payment amount for dual eligible individuals. Research conducted by Dobson DaVanzo & Associates, LLC projects that a home health co-payment could drive up Medicaid costs by as much as $2.4 billion nationally over ten years.

  - Applying a co-payment for home health services may lead to patients refusing to accept needed home care services. HCA member agencies that have contracts with Medicare managed care plans which charge home health co-payments based on episodes of care have found that many patients refuse doctor-ordered home health services or request termination of services once they become aware of the co-payment amount.

• Imposing cost-sharing for this population could lead to higher utilization of more costly skilled nursing care services, where there is no cost-sharing for the first 20 days of care and supplemental insurance may cover co-payments for days 21 to 100, leading to increased costs for Medicare. The Medicare Payment Advisory Commission (MedPAC) has cautioned that “A disadvantage of requiring beneficiary cost sharing for post-hospital episodes of home health care is that it could encourage beneficiaries to use higher cost post-acute care settings, such as skilled nursing facilities or inpatient rehabilitation facilities.”

• Collection of co-payments would be another federal administrative burden on home care providers; they would face difficulties in collecting the monies and suffer a loss in revenues due to uncollected co-payments. In New York State, home care providers have had negative average Medicare operating margins for ten years in a row and are already struggling with reimbursements cuts and other administrative burdens.

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