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Medicare's Home Health Benefit: Cost Sharing Issues and Options

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Summary

Cost sharing is a key element in the design of any health insurance plan and is used primarily to control utilization by making covered individuals aware of the cost of care. In addition, patients' cost sharing payments offset plan costs. Currently, home health care is the only Medicare-covered service, except for clinical laboratory tests, for which beneficiaries have no cost sharing.

Medicare's home health benefit has been subject to criticisms of inappropriate and over-utilization, particularly since home health spending began to rise rapidly in the late 1980s. Moreover, some questioned if rising utilization was due to the program's financing a substantial amount of long-term personal care by home health aides rather than medically necessary care by skilled practitioners as the law intends. Utilization and spending dropped dramatically as a result of a 1997 change to Medicare's home health payment system, but volatility in the program has evoked the suggestion that beneficiary cost sharing should be implemented as an additional tool for controlling program utilization.

Utilization control through implementation of cost sharing for Medicare home health services may be stymied by two factors: third party insurance that would insulate some beneficiaries from actually having to pay cost sharing (arguably those who are financially better off), and implementation in FY2001 of a home health prospective payment system (PPS), one objective of which was to curtail provision of unnecessary services by home health aides. Arguments in favor of cost sharing include consistency within the Medicare program, consistency with private health insurance policies, and generation of revenues to offset taxpayers' costs for Medicare. Opponents of cost sharing point out that beneficiaries who use home health services are atypically low income, elderly, with chronic health problems and limited ability for daily self care. Respondents to those arguments say that no other component of Medicare takes socioeconomic or self care status into consideration for cost sharing.

If Congress were to mandate cost-sharing for Medicare home health services, it would be important to design a system that did not create financial disincentives for beneficiaries to step down in a typical continuum in the cost of care, from inpatient hospital care, to skilled nursing facility care, to home health care. Requiring beneficiary cost sharing only for the first 60-day episode of care, or for all episodes of care, or only for second and subsequent episodes might depend on whether the PPS encourages home health agencies (HHAs) to provide unnecessary continuing episodes of care. Cost sharing amounts could be calculated in a variety ways, but considerations include balancing the affordability of out-of-pocket costs with consistency in cost sharing amounts for other Medicare services. This report will not be updated.

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Background

Medicare beneficiaries who are homebound are eligible for home health care based on the need for intermittent skilled nursing care, physical therapy, or speech-language pathology. For beneficiaries receiving at least one of these types of care, Medicare also covers occupational therapy and the services of home health aides and medical social workers. Beneficiaries may continue to receive occupational therapy after they no longer need other skilled care or therapies and may receive home health aide or social worker services as long as they receive occupational therapy. The services provided must be medically necessary and carried out under a plan of care prescribed and reviewed by a physician.[1]

When the Medicare program was enacted in 1965, Part A of the program covered up to 100 home health visits, at no charge to the beneficiary, provided the care followed a hospital or a skilled nursing facility (SNF) stay of at least 3 days.[2] Part B of Medicare also covered up to 100 home health visits to be used by beneficiaries who exhausted their 100 Part A post-hospital visits, by beneficiaries without a prior inpatient stay, or by those without Part A coverage. During the early years of the program, Part B-covered care required the beneficiary to meet the Part B annual deductible and to pay coinsurance of 20% of the Medicare-approved cost of care.

The Social Security Amendments of 1972 (P.L. 92-603) eliminated the 20% coinsurance requirements for home health care covered by Part B; the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) eliminated the 3-day prior hospitalization requirement for Part A home health coverage, the 100-visit limits under both Part A and Part B, and application of the deductible. Congress deleted these requirements because it was thought that the limits would cause beneficiaries

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[1] Medicare's home health benefit is targeted at beneficiaries needing skilled nursing care and therapies and has never been intended to cover long term personal care and assistance for frail elderly or disabled individuals. After a stroke, injury, or illness, some beneficiaries do not regain full independence in performing activities of daily living and require personal assistance and care on a long term basis. In these kinds of situations it may be difficult to determine when the need for skilled care ends and long term personal care begins, although program guidelines try to clarify the distinction between the need for skilled care and lower levels of care.

[2] Medicare covers SNF care only if it follows a hospitalization of at least 3 days.

who needed extensive visits to seek costly institutional care instead of home care, particularly those with Part A coverage only.[3, 4]

The liberalizations in OBRA 1980 resulted in an increase in the proportion of beneficiaries receiving home health benefits from 3.4% in 1980 to 5.1% in 1985. Medicare spending for home health more than doubled over that period. However, tight administrative rules regarding eligibility for home health care constrained continued expansion of spending for the benefit. Utilization and costs did not increase significantly until settlement of a class action suit in 1987 led to loosening of home health eligibility and benefit guidelines.[5]

Home Health Aide Services. A controversial component of Medicare's home health benefit is coverage of home health aide services. Aides carry out routine medical tasks and procedures, but they may also provide personal care such as bathing, dressing, and certain household chores. Medicare coverage of home health aide services ends when a patient no longer qualifies for in-home skilled nursing care or therapy. It is alleged that homebound beneficiaries sometimes continue to be certified as needing minimal intermittent skilled nursing care (say, two skilled nurse visits a month) in order to continue their qualification for regular visits by a home health aide. Some say that such beneficiaries are actually receiving, at no charge to them, long term assistance with activities of daily living, which is not medically necessary and therefore outside the scope of Medicare's home health benefit.

Medicare Payment for Home Health Care

In the early years of the program, Medicare reimbursed home health agencies (HHAs) for their reasonable costs. The 1972 legislation eliminating coinsurance for Part B-covered home health services also provided authority for Medicare to limit its payments for services. Starting in 1979, Medicare implemented limitations on cost reimbursements to HHAs, and that general system remained in effect until October 1, 2000, when Medicare implemented a prospective payment system (PPS) for HHAs. Under the PPS, agencies receive predetermined, fixed amounts per 60-day episode of home health care for each individual beneficiary served. Beneficiaries are categorized into one of 80 different payment groups (known as home health resource

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[3] U.S. Department of Health and Human Services. Health Care Financing Administration. *A Profile of Medicare Home Health: Chart Book*, August 1999. p.81.

[4] The Balanced Budget Act of 1997 shifted the financing of posthospital home health visits in excess of the first 100 visits from Part A to Part B, and continued the policy of no beneficiary cost sharing for services charged to Part B. The change is essentially a bookkeeping operation and is of no consequence to beneficiaries and home health agencies (HHAs.) The purpose of the change was to reduce costs paid from the Hospital Insurance Trust Fund, which finances Part A benefits only.

[5] U.S. General Accounting Office. Health, Education, and Human Services Division. *Medicare: Home Health Cost Growth and the Administration's Proposal for Prospective Payment*, Statement of William J. Scanlon, Director, Health Financing and Systems Issues, before the Subcommittee on Health and Environment, Committee on Commerce, House of Representatives. March 5, 1997.

groups or "HHRGs"), depending on the type and intensity of care to be furnished. (Payments are adjusted for relative differences in area wages.)

Beneficiary Cost Sharing for Medicare Services

Home health care is the only Medicare-covered service, except for clinical laboratory tests, for which beneficiaries currently have no cost sharing. Inpatient hospital stays are covered by Medicare after the beneficiary pays a deductible of $812 (in 2002), but no coinsurance is charged until the hospitalization exceeds 60 days. (Most inpatient stays are shorter than 60 days.) Beneficiary coinsurance per day of inpatient care is $203 for day 61 and continuing through day 90, after which the daily amount doubles (to $406 in 2002) for days 91 through 150. Days 91 through 150 are referred to as "lifetime reserve days," and are available only once in a lifetime.

SNF care is often the second step in the continuum of a beneficiary's recuperation from an acute illness or injury. Patients needing daily skilled nursing care or therapy but who do not need to remain in a full service acute care hospital may receive care in a SNF with no cost sharing for the first 20 days (provided the prior hospitalization lasted at least 3 days). Thus, under current law, beneficiaries have no financial reason to object to moving from a hospital to a SNF. Starting with day 21 in a SNF, however, beneficiaries pay $112 per day (in 2002) through day 100, but Medicare covers no SNF care after 100 days. Most SNF stays end before 20 days; the average stay in 1999 was 23 days.

Once a beneficiary no longer requires either hospitalization or daily SNF care, he or she may be discharged to home where, as long as the beneficiary is homebound, Medicare covers medically necessary intermittent or part time skilled nursing care or restorative therapies as well as occupational therapy, nurse aide, and medical social services. Because there is no cost sharing for home health services, under current law, beneficiaries have no financial reason to object to being discharged from an inpatient facility to receive home health services. The basis for the requirement that beneficiaries be homebound in order to qualify for home health care is to restrict the benefit to individuals who are unable to travel to a physician's or therapist's office or to an outpatient facility for ongoing care. Once a beneficiary can leave home regularly, ongoing care is covered only in outpatient facilities in which services are generally less costly than when delivered one-on-one in a patient's home.

Home Health Costs and the Cost Sharing Issue

The cost-sharing features of health insurance plans include beneficiary deductibles (a specified amount which the patient must pay for covered care before plan payments begin); coinsurance (a percentage of a plan's approved amount for care or services), or copayments (a specified dollar amount an enrollee must pay per unit of service, such as $15 per doctor visit).

Cost sharing is a key element in the design of any health insurance plan and is used primarily to control utilization by making covered individuals aware of the cost of care. Patients' payments also offset plan costs. In the past, Medicare's home health benefit has been subject to criticisms of inappropriate and over-utilization.

These concerns intensified as home health spending began to grow rapidly in the late 1980s, rising from $2.0 billion in 1988 to $18 billion in 1996, an average annual increase of 31%. This spending growth reflected both increasing numbers of beneficiaries served and more than a three-fold increase in the average number of visits per user. The causes for the increases are generally attributed to a 1987 lawsuit settlement that led to liberalizations in the definition of "intermittent" and "part-time" used to determine covered services; to a payment system that inherently motivated HHAs to provide increasing numbers of visits per eligible beneficiary (HHAs were paid for each visit made to a beneficiary); and to a lack of incentives for beneficiaries to be judicious about the amount of services they consumed. In addition, some questioned whether Medicare's home health benefit was being used to cover care for those whose real need was long-term personal care and assistance rather than acute care, pointing to the growing proportions of all visits that home health aide visits accounted for (one-third in 1987 and 48% in 1997).[6]

In the Balanced Budget Act of 1997, Congress sought to curtail the upward trend in home health spending by imposing a new limit on payments to HHAs (the so-called "per beneficiary limit"). This change removed the incentives for HHAs to maximize the number of visits to individual beneficiaries and reversed the increasing rate of utilization; spending dropped by about half by 1999. The average number of visits per home health user dropped from 74 in 1996 to 42 in 1999. Many observers note that the dramatic decline caused by the 1997 law was much larger than had been anticipated. This situation of uncontrolled spending increases followed by unanticipated decreases caused some to speculate that home health utilization and spending cannot be controlled appropriately and effectively by merely manipulating the payment system. Thus, they suggest adding a financial incentive for beneficiaries to participate in the decision about the quantity of care they use.

The first consideration regarding cost sharing for Medicare home health services is whether to impose such a requirement or not. If, on balance, Congress determines that a new cost sharing requirement for home health care is appropriate, the second consideration is how to set the amount.

The Home Health Cost Sharing Debate

Arguments in favor of beneficiary cost sharing are predicated on the assumption that beneficiaries would use less care if they had a financial incentive to do so. This assertion about beneficiary behavior is difficult to evaluate because about 24% of beneficiaries have individually purchased supplemental plans commonly referred to as "medigap" policies; about 36% have coverage obtained through a current or former employer (which might or might not pay home health care cost sharing, depending on the plan's design), and about 13% are low income beneficiaries also covered by Medicaid, which generally pays Medicare cost sharing for the beneficiary (1998 data).[7] If a new beneficiary cost sharing requirement for home health care were covered by supplemental insurance, it would probably add to the cost of those

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[6] *Ibid*. Health Care Financing Administration, 1999, p. 51.

[7] CRS Report RL31085, *Medicare Structural Reform: Background and Options*, by Jennifer O'Sullivan, Hinda Ripps Chaikind, and Sibyl Tilson, July, 24, 2001. p. 8.

policies, and some say these policies are already overly costly. Furthermore, it might have little impact on utilization because beneficiaries with supplemental coverage would remain insulated from the cost of care.

Advocates of cost sharing point out that all other Medicare-covered services require cost sharing (except clinical laboratory tests) and that cost sharing for home health services would create consistency within the program. However, a frequently heard objection to this rationale is that Medicare data show that home health users are different from Medicare beneficiaries in general in that they tend to be older, to be lower income, to live alone, and to have more impairments in their ability to perform activities of daily living, such as bathing, dressing, and toileting; cost sharing opponents say that these beneficiaries are less able than others to afford the premium for a medigap policy and are unlikely to have third-party insurance from a former employer. Thus, it is said that home health cost sharing could increase out-of-pocket costs for those least able to afford it, thereby reducing access to needed services or hastening a move to institutional long-term care.

Cost sharing proponents respond that (a) Medicare is not a welfare benefit, (b) very low income beneficiaries receive assistance with their cost sharing through Medicaid, (c) cost sharing for other Medicare-covered services does not apply differently depending on the socioeconomic status of beneficiaries, and (d) cost sharing would deter beneficiaries from seeking to prolong minimal use of skilled care in order to use home health aides for cost-free personal assistance with activities of daily living. Again, long term care for those needing personal assistance is not covered by Medicare.

Another argument supporting home health cost sharing is that private health insurance plans generally require it for enrollees using home health services. Implementation of cost sharing for Medicare home health care would move toward replication of the design features of private health insurance. This factor is particularly cogent for those who advocate restructuring Medicare along the lines of private insurance, including doing away with the situation in which most beneficiaries have "first dollar coverage," meaning a third-party insurance plan picks up the first dollar's worth of health care used.

An issue raised in opposition to home health cost sharing focuses on the disincentives it might create for beneficiaries to agree to move down in the level of care they are receiving. For instance, beneficiaries who might be discharged from a hospital when home health care is available would have a financial reason to object to discharge if they would be required immediately to make another out-of-pocket payment. Once the inpatient hospital deductible is paid, there is no additional cost sharing for staying longer in the hospital (at least, up to the first 60 days). Similarly, patients who might be discharged from a SNF within the first 20 days (while there is no cost sharing) would have a financial reason to object to being discharged to home health services if it implied an immediate out-of-pocket expenditure (unless the beneficiary's other coverage would pick up the cost sharing). As a result, hospital costs might rise if certain patients stayed longer, leading to pressure to increase payments to hospitals. Because Medicare pays SNFs for each day a beneficiary is in care, delaying discharge to home health care could result in increased Medicare SNF

payments. However, the disincentives are likely to apply only to beneficiaries without supplemental insurance that would pick up the home health cost sharing.

Arguments made in the past about the need for beneficiary cost sharing as a way to curtail over-furnishing of visits by HHAs may no longer be salient. Since implementation of the home health PPS on October 1, 2000, HHAs do not have a financial incentive to provide unnecessary home visits because Medicare pays agencies one amount per 60-day episode of care. The only possibility for over-supply of care under the new payment system might be that agencies could stint on care during an initial 60-day episode and seek certification for a second episode of care for some patients, thereby triggering another payment. Beneficiaries who feel they don't really need care after the first episode might object to a second episode if they had a financial reason to do so. If data eventually indicate that the number of beneficiaries certified for multiple episodes of care is too high, a requirement for cost sharing for second and subsequent episodes might be appropriate.

Finally, some opponents note that implementation of cost sharing would add new administrative burdens and costs to the program and to the responsibilities of HHAs.

Overall, it may be too early to know how home health utilization dynamics are working under the PPS. Although PPSs in general are designed to create incentives for providers to furnish care efficiently, new Medicare payment systems usually need some fine tuning as the Medicare program and providers gain experience with them. It is not yet clear how the new home health PPS has affected utilization or spending because of problems with collection of spending data. The General Accounting Office (GAO) estimated that, in the first 6 months of the PPS, payments to HHAs were about 35% higher on average than estimated agency costs for providing care, and preliminary data also suggest that home health patients are receiving fewer visits on average than had been foreseen.[8]

In summary, beneficiary cost sharing might cause more judicious use of home health if beneficiaries had a financial interest in the amount of care they consumed. Applying cost sharing to home health would be consistent with beneficiary payment requirements in other components of the program and would be consistent with private health insurance design. The major drawbacks are that as long as some beneficiaries have third party coverage, their utilization patterns and thus the goal of controlling utilization and Medicare costs might not be achieved to any significant degree. Moreover, higher medigap policy premiums might result, increasing beneficiary out-of-pocket costs and perhaps forcing some to drop their medigap policies. Finally, the new home health PPS may, to a great extent, obviate the need for beneficiary-based utilization controls because the payment system no longer has strong financial incentives for HHAs to oversupply services, although beneficiary cost sharing might be appropriate if continuous and multiple 60-day episodes emerge as a pattern.

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[8] *Medicare Home Health Care: Payments to Home Health Agencies are Considerable Higher than Costs*, GAO-02-663, May 2002.

Alternative Approaches to Determination of Beneficiary Cost Sharing Amounts

Some say that cost sharing is important in order to contain costs; others say those savings come at the expense of deterrence of use of needed and preventive services. Some say cost sharing is needed to curtail use of marginal or ineffective care; others that beneficiaries need protection from cost sharing that would increase their out-of-pocket costs. Any of these statements could be true, depending on how the cost sharing is designed. Unfortunately, there are no data to inform the debate on the effects on elderly people of cost sharing or alternative designs or amounts.[9]

Applicability of Cost Sharing to Post-institutional Care and Community Beneficiaries. If it were to be decided that cost sharing should be implemented for home health care, an initial decision would be whether there should be a distinction between care that follows a hospitalization (or a covered SNF stay) and care that does not. (Cost sharing under the original Medicare program had such a distinction.) If cost sharing were required for all patients, including those with a prior hospitalization, there could be disincentives for patients to agree to discharge from a hospital or a SNF to home health care if they would be required to make an immediate out-of-pocket payment. If cost sharing were applicable only to care not following a hospitalization, some "community beneficiaries" (defined as those without a prior hospitalization) might seek hospitalization to avoid home health cost sharing when they have insurance that pays the hospital inpatient deductible. If supplemental insurance were to pay home health care cost sharing also, the effects of home health cost sharing for all beneficiaries with supplemental insurance would be neutralized.

Home health care is intended for those whose primary need is for skilled care, and the services are required to be reasonable and "medically necessary." In many community beneficiary cases medical necessity is hard to establish with certainty. Although program guidelines try to distinguish between the need for skilled care versus unskilled care, there is little information on what the norms are for covered home health care. Some favoring home health cost sharing say that community beneficiaries are often actually seeking coverage of care for ongoing chronic conditions and long term care and personal assistance. Depending on the structure of the cost sharing and how it is covered under supplemental insurance policies, cost sharing might weed out such use by community beneficiaries.

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[9] One of the best sources of information on the effect of cost sharing on health care utilization is the Rand Corporation's Health Insurance Experiment carried out in the 1980s under contract with the U.S. Department of Health and Human Services. The Rand Health Insurance Experiment carried out in the 1980s concluded generally that people use fewer services when they are required to pay for them. The research found that coinsurance reduces the amount of care individuals seek, but, once care is sought, the amount received appeared to be controlled by the treating physician rather than the patient's cost sharing. However, elderly individuals and Medicare beneficiaries were not included in the population studied. (See *Benefit Design in Health Care Reform: Patient Cost-Sharing*, Office of Technology Assessment, OTA-BP-H-112, September 1993.)

Design and Amount of Cost-Sharing. Beneficiaries might be required to (a) meet a deductible at the start of an episode of home health care; (b) pay a flat dollar copayment per episode (similar to a deductible); or (c) pay coinsurance determined as a percentage of the applicable HHRG or some other amount. A combination of these cost sharing features could be used.

Deductibles and copayments. A one-time annual deductible might be based on some concept of the average Medicare payment for a unit of home health care. For example, the inpatient hospital deductible was set initially to equal the average cost of a day in a hospital, updated over time (although updating the amount and keeping it affordable have been problematic). According to the GAO's preliminary estimates, average HHRG payments for 60-day home health episodes during January through June of 2001 were about $2,691. The GAO found that home health patients received an average of 22 visits during this time period, for an average cost of about $122 per visit.[10]

This method for establishing a deductible is roughly modeled on the inpatient deductible, but it has several drawbacks. The number will change over time, and could change dramatically as the new PPS is refined. It is also higher than the $100 annual deductible applicable to all outpatient services, and thus, appears out of line (although some argue that the $100 Part B deductible is out of date).

Alternatively, a deductible or copayment could be established that is not based on home health costs. It could be set at, say, half of the Part B deductible, which would be $50 per year, or some other proportion. This amount is also less than the current daily copayment for a stay in a SNF after 20 days ($112), and thus, there would be little financial incentive for a patient to continue to stay in a SNF past 20 days.

If the hypothetical payment of $50 were to be characterized as a copayment rather than a deductible, it might be charged at the start of every 60-day home health episode in order to deter the program's being used as long term care. However, to protect beneficiaries' out-of-pocket costs, the copayment could decline after the first episode, and/or be subject to an annual cap. An advantage to this approach is that a straightforward updating procedure could be applied, such as the home health market basket index increase or the most recent cost-of-living adjustment applicable to Social Security cash benefits.

Coinsurance. Coinsurance generally is a percentage of the recognized cost of care used. Medicare Part B-covered services usually require beneficiaries to pay 20% of Medicare's approved amount, and Medicare pays 80%. If applied to home health care, a beneficiary could be charged 20% of the Medicare payment for the HHRG into which he or she is classified for home health care. According to the GAO's preliminary estimates, in 2001, episode payments ranged from $1,114 to $5,947. At 20%, cost sharing for those 60-day episodes would be $223 and $1,189 respectively. Although using this method to establish coinsurance would have to await better data on care used under the new PPS, the amounts appear high in relation

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[10] *Ibid*. General Accounting Office.

to other deductibles and cost sharing in the program. The amounts could be adjusted by, for example, dividing them by 60 for the total days in an episode or by the number of visits planned for the patient during a 60-day episode. Dividing by 60 days would result in a total coinsurance amount of $3.71 for the lowest cost episode (20% of $1,114 divided by 60) and $19.82 for the higher cost episode (20% of $5,947 divided by 60). Dividing by the number of visits a beneficiary is scheduled to receive rather than by 60 days would yield a larger cost sharing amount, but, within one HHRG, beneficiaries with a low number of visits would pay more than those with a higher number of visits.

Although some might argue that a methodology such as this is appropriate because it produces a coinsurance amount that is tied to Medicare's costs for the beneficiary's care, critics might say it "penalizes" those who are the most ill and need the most or the costliest care; moreover it appears to be overly contrived, and in future years, as utilization patterns and costs change, the numbers could lose credibility. Nevertheless, there is precedent in the Medicare program for charging the very ill who receive substantial care more than those who use less, i.e., beneficiaries pay more if they are so ill that they remain hospitalized for more than 60 days or are cared for in a SNF for more than 20 days.

Alternatively, cost sharing could apply to second or subsequent episodes of care only. Such a policy would not create incentives for beneficiaries to object to moving to home health care from a hospital or SNF stay and could deter inappropriate use of extended episodes of care.

Concluding Considerations

The reasons for and against implementing cost sharing for Medicare home health services may be stymied by the availability of third party insurance that would insulate some beneficiaries (allegedly those who are financially better off) from the very reasons for implementing cost sharing, that is, to provide financial incentives for beneficiaries to use services more judiciously. Although Congress could change the law to disallow coverage of home health care cost sharing under supplemental policies, it could be argued that such an arrangement would discriminate unfairly against home health users unless it were also to disallow coverage of most or all other Medicare cost sharing. Modifying the coverage rules for supplemental insurance in this way would be a policy change of substantial proportion, and it would be likely to take debate on the issue far beyond the home health benefit.

The design of the new home health PPS should curtail the overutilization problems that plagued the program in the past; some believe it obviates the need for cost sharing. Although coverage of cost sharing by supplemental insurance policies and implementation of the PPS may take the edge off some arguments for cost sharing as a utilization and cost control device, other reasons supporting cost sharing include consistency within the Medicare program, consistency with private health insurance, and generation of revenues to help offset taxpayers' costs for Medicare.