

# Committee on Ways and Means

## Medicare Prescription Drug and Modernization Act of 2003

### *Why a Co-payment for Home Health Services Is Important*

- **Equal Treatment.** Home health is the only service where there is neither a deductible nor a copayment. The typical beneficiary receives \$3,000 dollars worth of free home healthcare.
- **Keeps Beneficiary Premium Costs in Check.** Home health spending is increasing rapidly, rising almost 13 percent a year between 2004 and 2013 (CBO). In fact, the Congressional Budget Office estimates home health will have almost tripled in size in that same time period. When spending dramatically increases, so do beneficiary premiums because they are tied to the program's costs.
- **Deters Unnecessary Utilization.** According to the GAO and CMS, it is difficult to determine if the beneficiary needs home health. Requiring beneficiaries to share the cost of home health services encourages them to use care more prudently.
- **No Impact On Poor Beneficiaries.** The Bill exempts dual eligible and qualified Medicare beneficiaries (QMBs) and other groups (Q1s and SLMBs) from the co-pay.
- **Minimal Co-payment.** Only 1.5 percent (\$40 to \$50) for every 60-day episode of care would be collected compared to 20 percent collected on most Part B services. For instance, over a comparable period, a beneficiary might pay \$90 dollars for cardiac rehabilitation in the physician office, \$151 for cardiac rehabilitation in the hospital outpatient department, and \$48 for physical therapy.
- **Low Administrative Costs.** For the 90% of beneficiaries that have some kind of supplemental policy, the Medicare program collects the co-payments by automatically crossing over the claim to their insurance companies. Thus, copayments generate little administrative cost for an agency. Besides, the smallest sole practitioner office has to collect copayments, so can home health agencies.