REFORMING MEDICARE

Option: Increase Medicare Cost-Sharing for Home Health Care, Skilled Nursing Facility Care, and Laboratory Services

Medicare does not charge a copay for patients whose doctors prescribe home health care or for the first 20 days in a skilled nursing facility. Several proposals would require a copay for home health care, including one that would require a payment of $100 for home health episodes with five or more home health visits and add copays for the first 20 days of care in a skilled nursing facility. Medicare does not currently require a copay for laboratory services (such as blood and diagnostic tests). A number of proposals would require beneficiaries to pay 20 percent of the cost of laboratory services.

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Argument for:

Imposing a copayment for home health, skilled nursing facility (SNF), and laboratory services will discourage unnecessary use of these services. Since Medicare beneficiaries will be directly responsible for part of the cost, they will be more careful and deliberate about determining whether they need to use these services.

Studies have found that people use more health care services when there is little or no cost-sharing in place. For example, home health visits are one of the few services covered under Part B that do not require a copayment. Home health use has increased significantly in the past 10 years, which suggests that there may be overuse of these services. Use of laboratory services, which also does not require a copayment, has also increased. If cost-sharing were introduced, beneficiaries would have more of an incentive to talk to their provider about the necessity of the services being prescribed.

Shifting more of the cost for home health, SNF, and laboratory services to Medicare beneficiaries will also reduce Medicare costs and help to improve the long-term stability of the program. For example, adding a home health copayment could save the Medicare program as much as $40 billion over 10 years, depending on the copayment size and when it was implemented. Another study found Medicare savings of $21 billion over 10 years if SNF cost-sharing were increased. Savings estimates from adding laboratory test copayments are as high as $16 billion over 10 years, depending on the size of the copayment.

Most Medicare supplemental insurance (such as Medigap) would cover at least a portion of the cost-sharing, which would lessen the financial burden of these proposals on the majority of beneficiaries who have supplemental coverage.
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Argument against:

Many Medicare beneficiaries will have trouble affording the copayment amounts, particularly those who are low income and do not qualify for any additional assistance (such as from Medicaid, a federal-state program that helps low-income people). These individuals may end up not getting needed care or services.

Studies have shown that Medicare beneficiaries using home health and skilled nursing facility services tend to be sicker and poorer than the average Medicare enrollee. Under some proposals, Medicare beneficiaries without other supplemental coverage could end up paying significantly more for these services. For instance, some could pay up to $1,180 more if they stayed in a SNF for 27 days, and some could pay up to $600 more for home health services. Not everyone can afford these higher costs, and some Medicare beneficiaries may avoid using these services, which may be medically necessary, or seek less appropriate care. This could lead to more emergency room visits or hospital admissions down the road, which could end up costing the program even more money.

Even Medicare beneficiaries with supplemental policies could face higher out-of-pocket costs, as premiums would likely rise to offset the higher copays. State governments would also pay more, as Medicaid would be responsible for the copayments of low-income Medicare beneficiaries who receive assistance from Medicaid.

Finally, patients are in no position to determine whether tests ordered by their health care provider are medically necessary. Patients generally follow the recommendation of their provider—thus, reducing unnecessary tests or services should be done at the provider level, not by limiting care to patients.

*Avalere Health, LLC is a leading advisory company focused on health care business strategy and public policy.*