ISSUE BRIEF

SNF Cost-Sharing Proposal Could Raise Medicare Hospital Spending and Worsen Beneficiary Outcomes

Background: Medicare beneficiaries currently do not have cost-sharing obligations for the first 20 days of a skilled nursing facility (SNF) admission. Thereafter, beneficiaries are responsible for a copayment ($144.50 per day in 2012). Twenty percent of Medicare beneficiaries requiring SNF care do not have supplemental coverage (Medigap, employer-sponsored insurance or Medicaid) and make these co-payments out-of-pocket. Half of all SNF stays are 20 days or fewer; therefore the proposed co-payment could affect approximately 1 million beneficiaries.[i]

Proposal: Proposals have been offered to impose a first-day SNF co-payment on all Medicare beneficiaries.[ii] Supporters suggest that a first-day SNF co-payment could discourage medically unnecessary SNF utilization by shifting costs to beneficiaries.

Impact: Higher Costs, Decrased Quality Of Care

Any projected Medicare savings that would result from imposing additional out-of-pocket costs on SNF beneficiaries must be weighed against the potential for poorer outcomes and placement of patients in higher cost settings where co-pay requirements are not required.

Medicare beneficiaries are likely to postpone needed care. Research demonstrates that imposing higher cost-sharing responsibilities on patients reduces both necessary and unnecessary care - understandably, patients can't distinguish between the two.

Medicare spending for hospital care is likely to increase. If beneficiaries forego needed skilled nursing care due to first-day cost sharing, and instead go home prematurely, they will be at higher risk for readmission. For example, a 10% increase in hospital stays would increase Medicare inpatient hospital spending by $5 billion over 10 years.[iii]

Cost-sharing can lead to adverse health outcomes in vulnerable populations such as the elderly and chronically ill (e.g., Medicare SNF users).[iv]

Cost-sharing disproportionately affects lower-income beneficiaries, because the cost-sharing charges represent a higher percentage of their income or other resources. Of Medicare SNF users with no supplemental insurance, **65% have incomes below $25,000**. A co-payment of $1180 for the first 20 SNF days would amount to at least 5% of annual income for these beneficiaries.[v]

Alliance Position

Current Medicare policy regarding cost-sharing for SNF care should remain unchanged. Absent systemic restructuring of the post-acute delivery system, policy makers should not impose a SNF cost-sharing requirement on Medicare beneficiaries.

In Context: $65 Billion 10-Year Reduction in SNF Medicare Payments (FY 2012-FY 2021)

Productivity Adjustment (ACA-mandated): $34 Billion; **Forecast Error (Case-Mix) Adjustment:** $16 Billion; **Forecast Error (Market Basket) Adjustment in FY 2011 Rule:** $3 Billion; **Bad Debt (Middle Class Tax Relief & Job Creation Act of 2012):** $3 Billion; **Sequestration (1/1/13):** $9 Billion (Source: Avalere Health)

The Alliance For Quality Nursing Home Care

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i. MedPAC. MedPAC Report to Congress, Medicare Payment Policy. March 2012.

ii. CBO. Reducing the Deficit: Spending and Revenue Options. March 2011. CBO proposes a first-day SNF co-payment equal to 5 percent of the inpatient deductible. The projected daily copayment in 2013 is $59.

iii. Avalere Health analysis

iv. Manning WG, et al. Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment.

v. American Economic Review, vol. 77, no. 3, June 1987; and Newhouse JP, the Insurance Experiment Group. Free for All? Lessons from the Rand Health Insurance Experiment. Cambridge, MA: Harvard University Press, 1993.