

## Despite Criticism, The Affordable Care Act Does Much to Contain Health Care Costs

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October 2012

### Introduction

Critics of the Affordable Care Act (ACA) have argued that the law fails to address health care cost growth. They allege that though Americans rank concerns about access and costs as the two major problems with the health care system,<sup>1</sup> the legislation largely ignores the cost issue, focusing instead on coverage for the uninsured.<sup>2</sup> Many who make this argument tend to believe that medical malpractice is the major cost driver and since the legislation gave malpractice little attention, the law has no meaningful cost containment.<sup>3</sup> While malpractice may be a cost driver to be considered, it is clear that it is not the only factor. As we outline in this brief, there are many components of the Affordable Care Act that are designed to contain costs. Some of these are expected to lower the rate of growth in spending, particularly in Medicare.<sup>4</sup> Others are more experimental and hold promise to fundamentally change the way health care is delivered, improving quality and making the system more efficient.

It appears from Centers for Medicare & Medicaid Services (CMS) actuaries and Congressional Budget Office (CBO) projections that the rate of growth in health care spending has already slowed, in part because of the economy, but also because of provisions of the Affordable Care Act.<sup>5</sup> In this brief we discuss the managed competition framework embedded in health insurance exchanges, the Medicare provider payment cuts, the excise tax on high cost health insurance plans and several other proposals designed to slow cost growth.

### Competition in Exchanges

Managed competition has been proposed for many years as a market-oriented strategy for containing health care cost growth. Under the ACA, health insurance exchanges will be developed in each state to facilitate a competitive marketplace for the purchase of private insurance coverage by nonelderly individuals/families and small employers (100 or fewer employees).<sup>6</sup> Among other roles, the exchanges will certify qualified health plans, contract

with insurance carriers, determine eligibility for financial subsidies for exchange plans or Medicaid, distribute subsidies, provide consumer-friendly information to help purchasers compare plans, and facilitate enrollment. Qualified individuals with incomes below 400 percent of the federal poverty level (FPL) (generally, legal residents without affordable employer-sponsored insurance offers and who are not eligible for public insurance programs) will be eligible for federally financed subsidies that lower the cost of purchasing nongroup health insurance in the exchange. The structure of the exchanges and the approach used to benchmark the amount of the premium subsidies should engender strong competitive pressures among insurers and provide incentives for enrollees to select lower-cost plans.

Insurers providing small group and nongroup coverage in or out of the exchanges will only be allowed to offer plans that fit into four tiers of actuarial value (AV)<sup>7</sup>—bronze (60 percent AV), silver (70 percent AV), gold (80 percent AV), and platinum plans (90 percent AV)—with each level differing primarily on cost-sharing requirements, as all will be required to offer the essential benefits as defined by the Department of Health and Human Services.<sup>8</sup> Within each AV tier, multiple insurers can offer products. Subsidies will be tied to the premiums of the second lowest cost silver plan offered in the area. Individuals who want a silver plan with a premium in excess of this benchmark, or a gold or platinum plan, will have to pay the full marginal cost of such a plan. Those with incomes below 250 percent FPL will also qualify for federal cost-sharing subsidies.

In theory, requiring enrollees to pay the full difference between higher-cost plans and the benchmark plan should lead to strong competition among insurers. Insurers will compete on network adequacy, service, and price. There will be risk adjustment to compensate insurers who get a bad mix of risks. This structure generally meets the criteria for managed competition.<sup>9</sup> Individuals will have to pay extra

premiums or can be expected to gravitate toward less expensive plans, those that have limited networks, those that are effective at managing care, and those using less costly providers. Individuals would also be expected to have plans with reasonably high deductibles and more cost-sharing.

How much this would affect health care spending is uncertain. Reduced variation in the types of plans offered in the small-group and nongroup markets, and consumer information produced by exchanges to assist individuals and groups in becoming more effective purchasers will also increase competitive pressures in these markets. Currently, these markets are often characterized by tremendous variation in plan options, but very limited information is made available *a priori* to potential consumers about the coverage they may be purchasing. Insurers are often more focused on strategies for gaining favorable risk selection than they are in competing based on price and quality. The exchange structure and the insurance regulation reforms included in the ACA should serve to direct insurers toward increasing the efficiency of providing care, thus lowering premium prices and increasing market share.

Having large numbers of insurers is not necessarily a blessing in the health care market if this means they each lack the market power needed to get a good deal from providers.<sup>10</sup> In some markets a single insurer may be so dominant that it is hard for others to enter because they don't have the market share to allow them to effectively negotiate with providers. An additional problem with competition in exchanges is that it is limited to the people in individual and small group markets who are enrolled in exchange plans. By our estimates, there will be about 45 million people entering either into the non-group exchanges or the Small Business Health Options (SHOP) exchanges.<sup>11</sup> Of course, the plans outside the exchanges will to some degree be competing with the plans inside, and if the plans inside are able to control health care costs more successfully, more people will gravitate toward purchasing coverage in the exchange, even without subsidies. Thus, there is likely to be some spillover to the outside market.

### Medicare Payment Reductions

A second major cost containment feature of the ACA is the reduction in annual market-based updates for Medicare payment rates to hospitals, skilled nursing facilities, home health agencies, and hospices, as well as reductions in Medicare disproportionate share payments and payments to Medicare Advantage plans. The lower provider updates are intended to reflect or encourage greater productivity in these

sectors. The CMS actuaries estimate that these provisions will have lowered the rate of growth in Medicare by 1 percent per year, or by more than 10 percent over 10 years.<sup>12</sup>

For skilled nursing facilities, home health agencies, and hospices, Medicare is the dominant payer and these providers have no other payers that can be expected to provide adequate cross-subsidies. As such, they will need to adjust their cost structures to be consistent with Medicare payments. However, the effects of constraining hospital inpatient updates may be more complicated, given the market power of many hospitals. A recent study found that 88 percent of large metropolitan areas are considered to have highly concentrated hospital markets,<sup>13</sup> contributing to the rapid growth in health care costs. A number of studies have shown that private hospital rates are higher in more concentrated markets, where it is difficult for private insurers to effectively negotiate or control rates.<sup>14</sup> But, Medicare's administered pricing system sets rates for diagnostic related groups with adjustments for geography, teaching and other factors; the market power of hospitals is not a factor.

Medicare is the largest payer for hospitals, and payment reductions will mean hospitals will either have to adjust their expenses or, if they can, increase prices to other payers. If hospitals are able to shift costs to their private payers because of market power, hospital expenses will increase despite Medicare restraints. If they cannot shift costs on to private payers, they will need to control expenses. The Medicare Payment Advisory Commission (MedPAC) recently showed that, in areas where insurers have more market power over hospitals, there is more financial pressure and hospital expenses are lower, and Medicare payments appear to be adequate.<sup>15</sup> Conversely, they found that where hospitals have strong market power relative to insurers, hospital expenses are higher and Medicare payments do not cover them. The MedPAC results suggest that cost shifting can only occur where there are weak payers and strong providers.

A 2004 study by Robinson foreshadowed these MedPAC results: In competitive provider markets, hospitals could not cost shift and thus controlled costs, while the reverse was true in concentrated markets.<sup>16</sup> Another recent study also confirms the MedPAC findings, concluding that on average providers shift only 21 cents for each dollar lost on Medicare; this implies that they cannot or do not shift the other 79 cents.<sup>17</sup> Thus, the efforts of the ACA to reduce Medicare payments should reduce hospital costs in many markets, but not all.

## Excise Tax on High-Cost Employer-Sponsored Insurance Plans

Beginning in 2018, the ACA will impose a new 40 percent excise tax on employer-sponsored plans costing more than a threshold premium level. The amount of the tax will be computed by the insurance carriers and added into the premium paid by those purchasing the insurance, thereby increasing the purchase price of coverage. The intent of this provision is to reduce the incentive for employers to provide more comprehensive plans than this threshold employer-based insurance plan. This approach is an attempt to address perverse incentives associated with the income tax exclusion for employer-paid insurance that increases in value with premiums. The threshold premium level for single coverage will be \$10,200 in 2018; the level for policies covering more than one person will be \$27,500 that year.

The thresholds used in 2018 will be adjusted upward if premium growth in the Blue Cross Blue Shield standard option under the Federal Employees Health Benefits Plan grows faster than an average of about 5.6 percent per year between 2010 and 2018. The thresholds will also be adjusted based on employers' workforce age and gender composition. The law also increases the thresholds for workers and retirees covered under employer plans in certain high-risk industries (e.g., police officers, firefighters, first responders, construction workers, agricultural workers, and others); their threshold for single coverage is increased by \$1,650 and for other coverage by \$3,450 in 2018. The threshold premium levels will increase each year after 2020 by the consumer price index for urban consumers (CPI-U).<sup>18</sup> Since health care costs and premiums will likely grow faster than the CPI, the threshold will become increasingly binding over time.

The largest effect of the new excise tax is predicted to be a shift in compensation away from health insurance benefits, toward wages as a consequence of some employers purchasing less comprehensive health insurance for their workers. This implies a consequent reduction in the utilization of health care services when these employees are faced with higher deductibles, larger co-payments, lower out-of-pocket limits, and possibly fewer covered benefits.

The magnitude of the savings in health expenditures resulting from higher out-of-pocket costs is difficult to quantify, even though there is an extensive literature related to the effects of cost-sharing on health expenditures. This literature has been summarized and analyzed most recently in a synthesis by Katherine Swartz.<sup>19</sup> The most comprehensive

analyses of the effects of cost-sharing on spending were done using the results of the Rand Health Insurance Experiment (HIE) in the 1970s.<sup>20</sup> While the structure of health insurance policies and patterns of use and spending in health care have changed significantly since then, those studies are still instructive. HIE researchers found that higher cost-sharing does reduce health care utilization, but only patient-initiated health care spending. Once a patient was under the care of a physician, the use of medical care did not vary as a function of cost-sharing, suggesting that the physician was directing medical use decisions at that point, not the patient.

Thus, it seems that increased cost-sharing will lead those with the lowest health care needs to forego patient-initiated spending. This, combined with the strongly skewed distribution of health care spending (i.e., only 10 percent of the population accounts for 65 percent of total spending),<sup>21</sup> means that the excise tax on its own is not likely to achieve significant health savings—at least initially. However, by using the CPI to update the tax threshold, more and more plans will get pushed into the taxable range and the impact of the tax could get stronger. Even though the highest spenders may still be relatively unaffected, because they are seriously ill and most of their expenditures are above out-of-pocket limits in insurance plans, recent analysis suggests that moderate limits on the tax exclusion (well short of eliminating it) can cause a shift to less generous coverage that could produce savings on the order of 1.5 percent of National Health Expenditures.<sup>22</sup> This would be a significant effect within the range of alternative cost containment policy options.

## Other Provisions

There are a number of other provisions in the ACA that have the potential to contain costs.<sup>23</sup> The ACA authorizes the establishment of a nonprofit corporation, the Patient-Centered Outcomes Research Institute, to conduct and broadly disseminate comparative-effectiveness research. This research effort is intended to inform “patients, clinicians, purchasers, and policy-makers in making informed health decisions”<sup>24</sup> regarding relative health outcomes, clinical effectiveness, and appropriateness of medical treatments and services. The law outlines the factors for the new Institute to use in setting research priorities, including disease incidence, prevalence, and burden in the United States (particularly emphasizing chronic conditions; gaps in evidence; practice variations and health disparities; potential for improving patient health, well-being, and the quality of care; and the effect on national health expenditures.

The law allows for the research produced by the Institute to be used in making coverage, reimbursement, and incentive decisions under the Medicare program, although a number of safeguards are put in place. For example, the Secretary of Health and Human Services (HHS) is prohibited from denying coverage of services or items “solely on the basis of comparative clinical effectiveness research,” and the law emphasizes that the research findings are not to be construed as mandates for coverage and reimbursement decisions. Moreover, the analytical information collected by the Institute may not be used for Medicare reimbursement and coverage decisions “in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.”<sup>25</sup>

Another provision establishes an Independent Payment Advisory Board that would make recommendations for payment cuts if Medicare expenditures per enrollee grow faster than GDP plus .5 percent. There are limits on the policies and providers affected. For example, it may not recommend policies that would change eligibility and beneficiary cost sharing or increase revenues. In addition hospitals and hospices could not be affected until 2020.

The ACA also allows for the establishment of Accountable Care Organizations (ACO), which would be designed to take responsibility for care of patients, coordinate care, and improve efficiency. The intent is to provide financial incentives to both improve quality and reduce costs. An expenditure target for the ACO would be established. If costs for the designated population could be provided at a lower cost, the ACO would share the savings with Medicare.

The Affordable Care Act also includes provisions for reducing payments to hospitals with high levels of readmissions. Specifically, starting in 2013, Medicare payments will be reduced for hospitals with high rates of potentially preventable readmissions, initially for three conditions: acute myocardial infarction, heart failure, and pneumonia. The hospital's actual readmission rate for these conditions will be compared to its expected readmission rate, and the hospital will be subject to a reduction in Medicare payment for excess readmissions.

The ACA also establishes pilot programs for Medicare to experiment with bundled payments. The focus would be on ten episodes, determined by the secretary of HHS. Bundled payments will replace the discrete payments for each service/provider with a global payment for some or all providers and services

related to a particular episode or condition. In the context of acute and procedural episodes (e.g. a hip replacement) a bundled payment could include reimbursement for an outpatient or inpatient episode and related care provided in other settings for a specific interval of time. A bundled payment for a chronic condition would cover all care related to that condition for specified period (e.g. twelve months). The intent is that bundled payments would allow hospitals and other providers more flexibility in allocating resources, and give them opportunities to share savings from their efforts to reduce complications and readmissions.

CMS already has a new office to improve the coordination of care between Medicare and Medicaid for dual eligibles, a population that accounts for about 15 percent of U.S. health spending.<sup>26</sup> Although there have been studies that failed to show savings from care coordination, more recent approaches seem to have more potential for cost savings.<sup>27</sup> Successful programs include interventions targeted at those most likely to benefit. These often rely on nurse and primary care physician teams to engage patients and their families, get providers access to timely information on hospital admissions and emergency room visits, encourage close interaction between care coordinators and primary care physicians, and place an emphasis on teaching self-management skills.<sup>28</sup> Even small reductions, in percentage terms, in spending on dual eligibles would yield large dollar savings.<sup>29</sup>

Other features in the ACA that also could save money are the provisions that affect payments to insurance companies. These include minimum loss ratios for plans selling in the individual and small group markets, requirements that states undertake review of insurer rate filings and the opportunities to adopt an active purchasing model in the exchanges. Exchanges could use the power provided by the ACA to exclude plans from participating based on price or premium growth, i.e., negotiating aggressively with insurers. Because a considerable amount of data collection authority has been provided to the HHS Secretary under the ACA, exchanges should be much better informed of the underlying costs driving price increases, allowing them to be effective negotiators to limit insurer rate increases.

## Conclusion

It is simply not correct to say that the Affordable Care Act ignores cost containment. Given the urgency of containing the high level of health care spending in the United States, the ACA attacks the problem through a large number of different provisions related

to public and private insurance. Prior experience shows some of these will contain cost growth, while others are more experimental but offer promise. Many policy options have been studied in recent years<sup>30</sup> and although some of these made their way into the ACA, it is clear that more could be done.

One area that is often cited as a major driver of excessive health care spending is medical malpractice and its impact of defensive medicine, i.e. providing marginal services to be prepared to defend against a potential lawsuit. Earlier analyses suggest that some savings could be achieved with medical malpractice reform. Mello et al. concluded that the medical liability system accounts for 2.4 percent of health care spending.<sup>31</sup> Caps on non-economic damages have been shown to have some effect on medical malpractice premiums paid by physicians and hospitals, though care needs to be taken in the design of such caps.<sup>32</sup> CBO has estimated that a \$250,000 cap on non-economic damages would result in savings of about 0.3 to 0.4 percent of national health spending.<sup>33</sup> If defensive medicine could be reduced, more could be saved. The upper bound seems to be around 1 percent of national health expenditures, but only if the care that is now provided for defensive reasons is eliminated and not continued in the name of “good and careful” medicine.

Other measures that would bring down health care costs (more than those already implemented) would be stronger limits on the exclusion of employer

sponsored health insurance premiums from income and payroll taxes and direct controls over provider payment rates, possibly as part of global budgets. Neither of these seems politically tenable at the moment and, in all likelihood, the best chance at cost containment over the next few years would be to allow the myriad provisions contained in the ACA a chance to have some effect.

These measures, and a variety of other factors, are already reducing projections of future health expenditures. The CMS actuaries recently projected health expenditures to increase by only one percentage point above GDP growth. They cite the shift to high deductibles in private insurance plans and the development of fewer blockbuster drugs, the adoption of tiered formulas, and greater use of generic drugs. But the actuaries also cite mandated reductions in Medicare fee-for-service rates, lower payments to Medicare Advantage plans, a shift of coverage from employer plans to Medicaid and health insurance exchanges, and the excise tax on high cost plan as reasons to expect lower health spending per capita.<sup>34</sup> For example, Medicare payments per capita are now projected to increase at 3.1 percent per year over the next decade (or 3.8 percent with a fix to the physician payment Sustainable Growth Rate formula), still lower than the projected increase in GDP per capita. While more could and perhaps should have been done in the Affordable Care Act, it is simply not accurate to argue that the law’s cost containment provisions are weak or non-existent.

## Notes

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7. Actuarial value is the average share of benefits covered by a health insurance plan that are reimbursed by the insurance plan, as opposed to being paid out-of-pocket by the enrollees.
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*The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.*

## **About the Authors and Acknowledgments**

Stephen Zuckerman is a senior fellow and John Holahan is the director of the Health Policy Research Center at the Urban Institute. The authors would like to thank Robert Berenson, Randall R. Bovbjerg, Lisa Clemans-Cope, and Linda J. Blumberg for their contributions to the papers drawn on in this brief.

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