

What Are the Provisions in the New Law for Containing Costs and How Effective Will They Be?

Timely Analysis of Immediate Health Policy Issues

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Health reform has several broad objectives, including expanding insurance coverage, containing the growth in health care spending, and improving quality of care. The provisions of the law related to coverage expansions are generally well-understood and likely to achieve their objectives. Policymakers used reduced payments to Medicare Advantage plans and many types of Medicare providers to finance about half the costs of coverage expansion. The types of limits put on Medicare payments have been used successfully in the past and, in addition to offsetting the costs of coverage, will extend the solvency of Medicare. Other provisions of the health reform law related to cost containment and quality improvement are less well-tested and, as a result, have greater uncertainty about their likely effects.

The lack of a clear consensus on how to contain costs led health reformers to include several provisions in the Patient Protection and Affordable Care Act to reduce costs.¹ These include:

- Health insurance exchanges that could promote competition among plans based on price and quality;
- An excise tax on high-cost health plans;
- Delivery system and payment reforms;

PPACA's cost-containment provisions are modest, but could help slow rising costs while sparking improvements in quality.

- The Independent Payment Advisory Board focused on slowing Medicare and private spending growth;
- Greater emphasis on prevention and wellness programs; and
- Broader efforts to reduce waste, fraud, and abuse.

The uncertainty about the cost-containing effects of some provisions was reflected in Congressional Budget Office (CBO) cost estimates. The CBO seems to have been conservative in assigning impacts to many ideas that have been highly touted, and it focused solely on the budgetary effects as opposed to overall health care spending.²

The Centers for Medicare and Medicaid Services (CMS) actuaries performed the only available analysis of the overall impact of health reform on national health spending.³ It showed that health expenditures as a share of the gross domestic product (GDP) would increase from 17.8 percent in 2010 to 21.0 percent in 2019. Without reform, health expenditures as a share of GDP were projected to be 20.8 percent in 2019. This implies that, taking into account reduced expenditures on Medicare, 34

million people would leave the ranks of the uninsured in 2019 at a net increase in spending of \$45.8 billion—less than a tenth of total projected health expenditures in 2019 under current law. This increase in spending may seem small relative to the increase in coverage. However, the provisions of the law aimed at cost-containment—especially in private health insurance—seem considerably weaker than those related to expanding coverage.

Health Insurance Exchanges

These entities will focus on providing individuals and small employers with a place to purchase health insurance. Exchanges have the potential to produce savings by lowering the costs of administering a health plan, particularly costs related to marketing and sales relative to the pre-reform environment, and by creating an environment in which plans can only compete for enrollees by offering low-cost, high-quality products. The exchanges, if functioning correctly, would eliminate the ability of health plans to select favorable risks through medical underwriting or varying benefit design. Instead, health plans would need to negotiate lower prices



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from providers, develop and implement approaches that could eliminate unnecessary utilization, and reduce their administrative costs. People purchasing coverage and receiving subsidies through the exchange have an incentive to select lower cost plans to avoid extra payments that would be required to enroll in more generous plans.

Excise Tax on High-Cost Health Plans

One provision aimed at encouraging health plans to gradually provide less comprehensive benefits is a 40 percent excise tax on health plans with individual premiums above \$10,200 and family premiums above \$27,500. The basic mechanism through which this tax will lead to cost containment is that it provides employers an incentive to reduce the generosity of benefits so that premium growth is controlled. This means that people will likely face higher deductibles and copayments, use fewer services, and potentially become more willing to join plans that limit provider choice (e.g., integrated delivery systems). Once premium growth is reduced, excise tax revenues would fall. However, economists and cost simulators assume that wages would grow more quickly as premium growth is slowed. This would result in an increase in payroll and income taxes that would offset the reduction in excise taxes. This tax will not go into effect until 2018 (the premium thresholds are projected to 2018). As a result, the effect of the excise tax during the first 10 years of health reform will be limited, both in terms of revenues it is projected to generate and cost containment. However, given that the thresholds that determine if a plan is subject to the tax are indexed to the general rate of inflation after

2019, CBO predicts that this excise tax is likely to have its biggest cost containment and revenue effects in the second decade of reform.⁴

Independent Payment Advisory Board (IPAB)

The IPAB will begin making recommendations in 2014. In any year in which the Medicare per capita growth rate exceeded the average of growth in the consumer price index (CPI) and the Medical Care CPI, the IPAB would be required to recommend Medicare spending reductions. Establishing price changes as a target for spending growth is an aggressive approach because it does not allow for spending growth that can result from changes in the volume or intensity of services. The IPAB recommendations would become law unless Congress passed an alternative budgetary savings. This body could have considerable power over some Medicare payment rates. However, at least initially, the IPAB's influence over Medicare payments may be limited because some provider groups are exempted—importantly hospitals until 2020. However, between 2015 and 2019 (the initial period during which IPAB's influence could be felt), the CBO estimates that this provision will still save Medicare \$15.5 billion relative to the current baseline.

The CBO goes on to conclude that IPAB's actions would increase payment rates for many providers below the rate of inflation. The CBO assumes that the IPAB would be “fairly effective in reducing costs beyond the reductions that would be achieved by other aspects of the legislation.” The importance of IPAB is that it would be required to make

recommendations that would control Medicare spending growth and that these recommendations could only be replaced by other policy options that would achieve comparable spending control. Congress would not have the ability to ignore the IPAB recommendations in the interest of protecting provider payments. Barring other legislative actions, IPAB could be one of the most important cost-containment provisions in the law and have a direct impact on government spending and deficits.

In addition to making policy changes that affect Medicare payments, the IPAB would also be required to make recommendations that could affect private health spending. Although these recommendations would not be binding, they could chart a credible path toward lower spending growth. Private payers (insurers and individuals) would have to work with providers and their representatives to implement these recommendations, in all or in part, but having this roadmap to follow could be a major improvement over the current state of affairs. The IPAB's ability to control Medicare spending, while maintaining beneficiaries' access to providers, could be limited if there is not a serious effort to control private spending at the same time.

Delivery System and Payment Reforms

This set of policy initiatives contains several approaches. If successful, they would all move the system away from one that rewards providers for more health care services toward one that reduces waste, slows spending growth, and rewards quality care. Policies initially focused on and tested through the Medicare and Medicaid programs could be adopted by other payers if they seem promising.

- One provision would encourage physicians and hospitals to form accountable care organizations (ACOs), which are intended to develop approaches to providing high-quality care at low costs. ACOs can be thought of as a set of providers, including primary care physicians, specialists, or hospitals, that bear responsibility for the cost and quality of care delivered to a subset of traditional Medicare program beneficiaries.⁵ ACOs would have to control traditional Medicare spending by providing financial rewards for good performance based on comprehensive monitoring of quality and spending. Any Medicare savings that emerge would be shared with the providers. Although many details of this policy need to be worked out, CBO projected that this provision would save Medicare \$4.9 billion. Presumably, some payment yet to be determined would go to the ACO, and some of that would be distributed to providers.
- Two provisions of the law would give hospitals a greater incentive to promote high-quality care and avoid unnecessary 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 three conditions with risk-adjusted readmission measures currently endorsed by the National Quality Forum. 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 its “excess readmissions.” The CBO estimates that this payment adjuster would save \$7.1 billion over 10 years. In addition, the law would continue the policy of denying Medicare payment for treatments associated with hospital-acquired conditions and extend this policy from Medicare to Medicaid. This should encourage hospitals to create systems that would lower the incidence of hospital-acquired conditions and, thereby, improve quality of care. The CBO estimates this would save \$1.4 billion, but that none of this would come from Medicaid.

- Several provisions aimed at improving efficiency could begin building a structure that would contain costs in the future, but were not scored by the CBO as producing savings during the first 10 years of reform. One such provision is related to a national pilot program on payment bundling in Medicare. Under this program, a payment would be made for all services provided during an episode of care as opposed to for individual services. The goal would be to promote efficiency while maintaining or improving quality. Alternative approaches could be tested in different areas and, if successful, could be expanded nationally. The law also requires that the Secretary of the Department of Health and Human Services (HHS) develop approaches to value-based purchasing that provide incentives to hospitals and physicians who achieve certain preset quality targets. Efforts will also be made to start a demonstration program to deliver

primary care services to chronically ill Medicare beneficiaries in their homes.

- The Center for Medicare and Medicaid Innovation would run several specific initiatives described here, and develop and test other approaches. Essentially, the goal would be to identify the encouraging options and extend their application. Although this is not very specific, the CBO credits this entity with achieving \$1.3 billion in savings over 10 years.

Medicare Payment Cuts

In addition to providing offsetting revenues to fund the coverage expansions, the reductions in Medicare payments through changes in Medicare Advantage rates and lower updates to encourage productivity improvement could be a spur to further cost containment. By 2019, CMS actuaries project that Medicare spending will be more than 10 percent below previously projected levels.⁶ Providers could respond to these lower payments by making substantial changes in the way health care services are produced that would lower the costs of care. If this occurred and private health plans tried to piggyback on Medicare policies, it could lead to lower prices for health care paid through private plans. The effect would be to slow health expenditure growth. Alternatively, if provider responses are limited and the history of private health plan payments to providers serves as a guide, providers with significant market power may simply attempt to offset the Medicare cuts by seeking higher provider prices. This cost-shifting behavior would limit any potential multiplier effects of the Medicare payment cuts on overall health care spending. If private payers

cannot control payments to strong providers, it could suggest a need for a strong public plan that would negotiate prices more aggressively or for explicit all-payer rate regulations that would determine what private plans would pay providers.

Prevention and Wellness Programs

The health care reform law includes several initiatives to reduce future spending by preventing disease and promoting wellness. Medicare will be changed so that an annual wellness visit is added to the guaranteed benefit package, at a CBO-estimated cost of \$3.6 billion over 10 years. In addition, Medicare would remove copayments for preventive care while limiting this enhancement in coverage to those services for which evidence suggests some benefits. These two provisions tend to have offsetting effects from a cost standpoint, according to the CBO. Similar to the Medicare provisions, private qualified health plans would also have to eliminate cost-sharing for recommended preventive services. States would receive an enhanced federal matching payment for Medicaid spending for these preventive services and immunizations. There are more provisions related to prevention and wellness. However, although the CBO tends to project the costs of these

programs, they do not assume much long-run savings. For example, though the costs of services designed to prevent the spread of diabetes are enumerated, the CBO does not attribute any benefits to these programs in the form of lower spending than would have occurred otherwise. Savings could be much larger if these programs prove effective and private insurers adopt them. There is evidence that the CBO may have been conservative in estimating the potential benefits from prevention and wellness programs.⁷

Reduce Waste, Fraud, and Abuse

Concern over public expenditures for services that did not need to be provided or were provided fraudulently suggests that people believe that spending can be controlled by ferreting out these services. Health reform included new resources and penalties to fight fraud in the Medicare and Medicaid programs. The CBO acknowledges that each \$1 invested in uncovering fraud generates \$1.75 in budget savings. Across all of the activities, the CBO projects that spending would fall by \$2.9 billion and revenues would increase by \$0.9 billion over 10 years. This might be an understatement if the incentives for waste, fraud, and abuse were changed

throughout the system, leading to a substantial change in provider behavior and service patterns.

Conclusion

Cost containment is likely to be the most difficult challenge facing health reform. As opposed to efforts to expand coverage, there is much less agreement on approaches that can be successful in controlling costs. Because of this, policymakers are trying a wide array of approaches that will draw on competition among health plans, taxes on high-cost insurance plans, delivery system and payment reforms, wellness programs, and direct controls over Medicare provider payments. The law also creates a new independent board that can directly influence Medicare payment policies and make recommendations to the private sector. Based on the projections by the CMS actuaries, there is a reasonable expectation that the combination of these efforts will allow for a significant expansion on coverage without an acceleration of cost growth. However, we will not know for years if the many opportunities for cost containment that the health reform law created will actually result in slower cost growth and avoid the need for stronger measures.

Notes

¹A summary of the new health reform law is available at <http://www.kff.org/healthreform/8061.cfm> (Kaiser Commission on Medicaid and the Uninsured).

²Congressional Budget Office, letter to the Honorable Nancy Pelosi providing an analysis of the reconciliation proposal, March 20, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf>.

³R. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act as Amended,'" April 22, 2010.

⁴Congressional Budget Office, March 20, 2010. All subsequent cost estimates of the various provisions in the Patient Protection and Affordable Care Act are drawn from this source.

⁵K. Devers and R. Berenson, "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" (Washington, DC: The Urban Institute, 2009).

⁶Foster, "Estimated Financial Effects," 2010.

⁷R. Berenson, J. Holahan, L. Blumberg, R. Bovbjerg, T. Waidmann, A. Cook, and A. Williams, "How Can We Pay for Health Care Reform?" (Washington, DC: The Urban Institute, 2009).

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