



Cost Containment in the Affordable Care Act: An Overview of Policies and Savings

May 2014

While there has been considerable media coverage about the insurance impacts of the Affordable Care Act (ACA), there has been less discussion of the law's changes to provider reimbursement policy, reforms to the delivery system, and investments in programs to improve the quality of care and constrain long-run growth in health care expenditures. And yet, the elements included in the ACA directed at cost and quality are likely to affect the practice of care for nearly every provider across the country. Although cost containment policies and initiatives are largely implemented through federal health programs—including Medicare and Medicaid—cost containment in these programs has important cost-saving spillover effects to private health care markets through changes in health care practices and pricing across sectors of care.¹

This paper focuses on ACA cost containment policies that target the delivery of health care at the provider level, and aim to reduce system-wide health care costs—for the federal and state governments, individuals, and employers—through delivery system reforms. This paper first describes the categories of policies in the ACA designed to contain costs. It then provides an overview of several policies in each category that are expected to reduce the rate of growth in costs. A companion paper, *An In-depth Look at 6 Cost Containment Programs in the Affordable Care Act*, provides a more detailed description of six specific policies or initiatives created by the ACA that are designed to affect system-wide growth in health care costs.

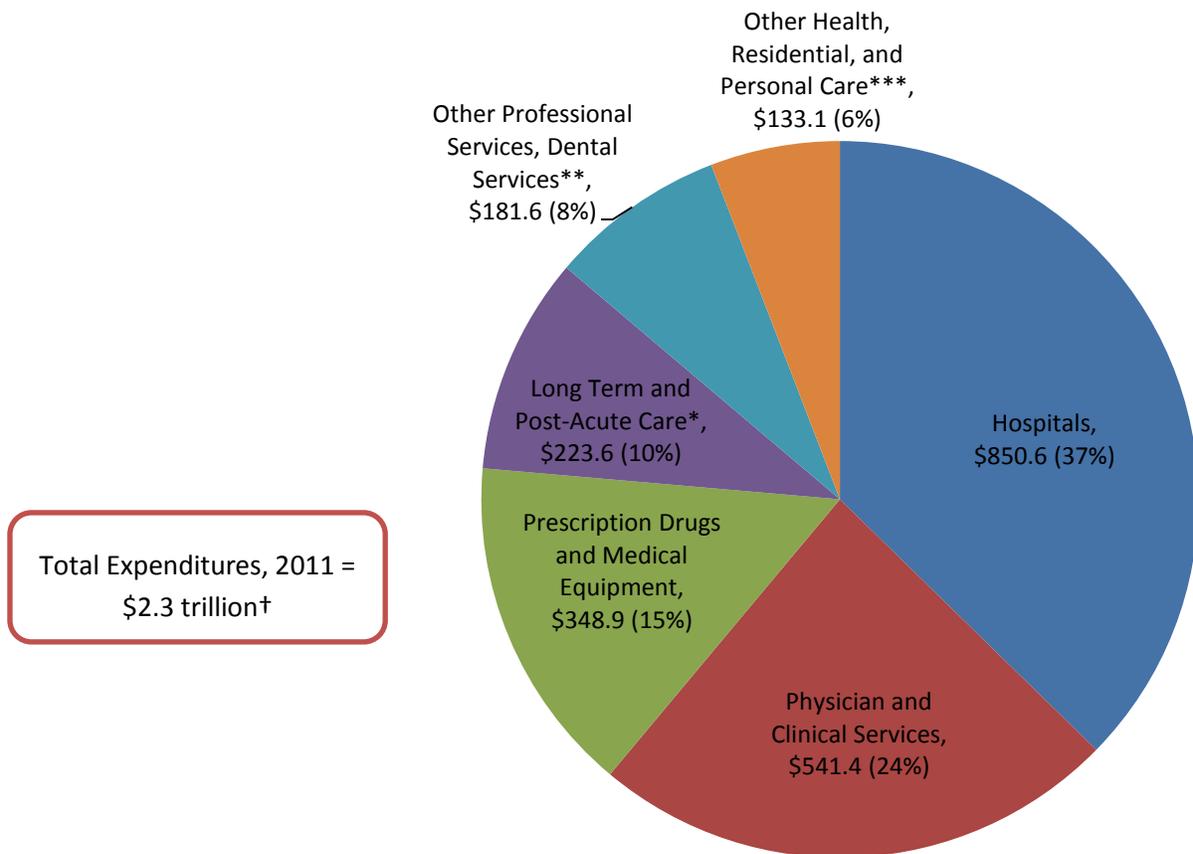
Health Care Spending

Hospital and physician spending account for almost two-thirds of total health care spending (Figure 1). Nearly all of the policies described in this paper include changes to hospital and/or physician care. Prescription drugs and medical devices, and long-term care and other facilities account for 39 percent of total health care spending. The ACA enacted important reforms in these areas as well.

The Center for Healthcare Research & Transformation (CHRT) sponsors research and public information to promote evidence-based care delivery, improve population health, and expand access to care. Housed at the University of Michigan, CHRT is a nonprofit partnership between U-M and Blue Cross Blue Shield of Michigan to test the best ideas for improving the effectiveness and efficiency of the health care system.

www.chrt.org

FIGURE 1: 2011 Personal Health Care Expenditures, by Sector (in billions of dollars)



†Personal health care comprises medical goods and services used to treat or prevent a specific disease or condition in a specific person. Also included in total national health expenditures (but excluded here) are government administration, net cost of health insurance, government public health activities, and investments (such as research).

*Includes Nursing Care Facilities, Continuing Care Retirement Facilities, and Home Health Care.

**Health care services rendered by practitioners other than physicians.

***Non-traditional settings including school health, worksite health care, Medicaid home and community based waivers, some ambulance services, and residential mental health and substance abuse facilities.

Sources: Micah Hartman, Anne B. Martin, Joseph Benson, Aaron Catlin, and the National Health Expenditures Accounts Team. National Health Spending in 2011: Overall Growth Remains Low, But Some Payers and Services Show Signs of Acceleration. *Health Affairs* 32, no. 1 (2013): 87–99; National Health Expenditures Accounts: Methodology Paper, 2011, Definitions, Sources, and Methods, *CMS*. Accessed Mar. 20, 2013 at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-11.pdf> (accessed 3/20/13).

How Are Health Care Costs Controlled?

Payment Reform

A significant share of the over \$500 billion in projected cost savings from the ACA derives from slowing the growth in reimbursement rates to providers and health plans, primarily in Medicare.² Targeted providers include hospitals, home health care agencies, nursing homes, hospice, ambulatory care

services, and other services. Payment reforms were based on recommendations from expert advisory panels and on the assumption that health care providers would make gains in efficiency or productivity in the delivery of health care similar to those in the rest of the economy. Figure 2 provides an overview of some of the payment reform policies and initiatives included in the ACA.

FIGURE 2: Selected Payment Reform Policies and Initiatives

Policy or Initiative	Description and ACA section number(s)	Projected Cost Savings over Ten Years*
Disproportionate Share Hospital Payments	Gradually reduces Medicare and Medicaid disproportionate share hospital (DSH) funding as more patients gain insurance coverage and uncompensated care declines (<i>§3133, 10316; Health Care and Education Reconciliation Act of 2010 (HCERA) §1104, 1203</i>)	\$36 billion
Hospital-Acquired Conditions	Reduces Medicare payments by 1% for hospitals with relatively high rates of hospital-acquired conditions among patients (<i>§3008, 2702</i>)	\$1.5 billion
Hospital Readmission Reduction Program	Issues penalties of up to 3% of payment to hospitals with excessive (relative to the national average) preventable hospital readmissions among patients with defined conditions. (<i>§3025</i>)	\$7 billion
Market Basket Updates	Reduces the rate of reimbursement growth through changes to providers’ annual market basket updates and inclusion of productivity adjustments into such updates (<i>§3401; HCERA §1105</i>)	\$160 billion
Medicare Durable Medical Equipment	Expands competitive bidding for durable medical equipment from 70 to 91 areas; requires that all payment rates are subject to competitive bidding or that rates are adjusted using the competitively bid rates (<i>§6410</i>)	\$1 billion
Prescription Drug Rebates	Increases minimum Medicaid drug rebate amount and expands scope of drugs covered by the rebate requirement; expands rebate requirement to drugs provided through Medicaid managed care organizations (<i>§2501</i>)	\$38 billion

*Savings estimates from Congressional Budget Office, March 20, 2010, letter to Honorable Nancy Pelosi. <https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>

Delivery System Reforms

This category of policies aims to change the way that health care is delivered. For instance, several initiatives seek to move away from paying providers a fee for each service they provide (i.e., fee-for-service) and instead provide reimbursement for an entire episode of care, or provide incentives for coordination of care across conditions and settings for a patient. Other reforms seek to improve quality and reduce wasteful spending by penalizing or rewarding providers based on measures of quality and/or

cost of care delivered. For instance, as part of the Hospital Readmission Reduction Program, hospitals that have high rates of patients readmitted to the hospital for the same condition within 30 days of discharge face a reimbursement penalty. Some of the ACA components in this category are optional for providers (such as the Bundled Payment for Care Improvement initiative). Also included in this category is the Center for Medicare & Medicaid Innovation (CMMI). The ACA established the CMMI with \$10 billion in funding over ten years to support the development and testing of innovative health care payment and service delivery models. The Congressional Budget Office (CBO) estimates that even with \$10 billion in funding, the CMMI’s activities will result in a net spending reduction. Figure 3 provides an overview of some of the delivery reform policies and initiatives included in the ACA.

FIGURE 3: Select Delivery Reform Policies and Initiatives

Policy or Initiative	Description (ACA section number(s))	Projected Cost Savings over Ten Years*
Accountable Care Organizations	Promotes Accountable Care Organizations as collaborative models where providers receive joint Medicare payments for patient care and share in savings achieved through better coordination of care (§3022)	\$5 billion
Center for Medicare & Medicaid Innovation	Established the Center for Medicare and Medicaid Innovation to test new payment and delivery models that can reduce health care expenditures; programs being tested include the Bundled Payment for Care Improvement (BPCI) Initiative, the Independent at Home demonstration and the Comprehensive Primary Care (CPC) Initiative (§3021)	\$1 billion
Value-Based Purchasing	Integrates measures of quality and efficiency into provider payments; hospitals face up to 2% of payments withheld and redistributed based on performance; physicians are penalized for non-reporting of quality measures and will have payments withheld and redistributed based on performance; other providers must meet quality reporting data requirements with possible future payment adjustments (§3001-3007)	Budget Neutral

*Savings estimates from Congressional Budget Office, March 20, 2010, letter to Honorable Nancy Pelosi. <https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>

Cross-cutting Policies and Initiatives

In addition to initiatives that result in immediate reductions in spending, there are also several cross-cutting policies and initiatives that span the continuum from prevention to care to enhance public health, decrease high-cost care, and improve the effectiveness of clinical care. Key examples include the following items, which are summarized in Table 3.

Prevention and Public Health Fund

Section 4002 of the ACA created the Prevention and Public Health Fund (PPHF) to improve health outcomes and restrain the rate of growth of health care costs in the private and public sectors. To achieve these goals, the PPHF is providing expanded and sustained funding to evidence-based programs that help prevent disease, detect disease early, and manage conditions before they become severe. The PPHF is also investing in programs to help states and local communities promote healthy living.³

The ACA originally designated a total of \$16.75 billion between FY 2010 and FY 2021 for the PPHF, with \$2 billion allocated annually thereafter.⁴ The PPHF has since experienced some funding reductions. In February 2012, the Middle Class Tax Relief and Job Creation Act cut PPHF funds by \$6.25 billion over nine years (FY 2013 to FY 2021) to fill budgetary gaps.⁵ The funds expected in FY 2013 were further reduced due to sequestration and the Department of Health and Human Services' (HHS) need to divert funds toward implementation of the Health Insurance Marketplace.⁶

The PPHF was appropriated \$1 billion for FY 2014 via the Consolidated Appropriations Act of 2014. This was the first time Congress detailed which agencies and programs would receive PPHF funds. Of the \$1 billion appropriated, the Centers for Disease Control and Prevention (CDC) received \$831 million, the Substance Abuse and Mental Health Services Administration (SAMHSA) received \$62 million, the Administration for Community Living (ACL) received almost \$28 million, and the Agency for Healthcare Research and Quality (AHRQ) received \$7 million. The PPHF lost \$72 million due to sequestration.⁷

Patient-Centered Outcomes Research Institute

The Patient-Centered Outcomes Research Institute (PCORI) is a nongovernment, nonprofit entity established by and funded through the ACA to support research on the risks and benefits, effectiveness, and appropriateness of different medical treatments. PCORI's work is intended to enhance health care knowledge, improve patient outcomes, and reduce costs by allowing public and private payers to focus their resources on high-value care. PCORI maintains a focus on clinical effectiveness research in vulnerable and high-risk populations typically underserved by research (such as racial and ethnic minorities, older adults, and rural residents).⁸ As of January 2014, PCORI has awarded 279 research projects and committed \$464.4 million in funding in 40 states plus the District of Columbia.⁹ To help guide the funding process, PCORI has established six multi-stakeholder advisory panels.¹⁰

Independent Payment Advisory Board

To moderate the long-term Medicare cost curve, the ACA created the Independent Payment Advisory Board (IPAB); a panel of independent advisors to be charged with recommending policies to slow Medicare spending if the growth rate exceeds a legislatively determined target growth rate. As of April 2014, nothing has been done to implement IPAB, which has been mired in controversy.

If implemented, IPAB would be prohibited from changing Medicare's eligibility rules or benefits, raising beneficiaries' out-of-pocket costs or taxes, or reducing payments to certain providers already affected by the ACA. However, Congress would need to consider its recommendations under expedited rules that

require a supermajority to override, and the IPAB recommendations would be automatically implemented by the U.S. Department of Health and Human Services (HHS) if Congress failed to act— either to adopt IPAB’s recommendations or develop its own comparable cost-saving policies. The CBO projected that from 2015 to 2019, IPAB policies would result in decreased Medicare expenditures of nearly \$16 billion.

FIGURE 4: Select Cross-cutting Policies and Initiatives

Policy/ Initiative	Description and ACA section number(s)	Projected Cost Savings over Ten Years*
Prevention and Public Health Fund	Instituted the Prevention and Public Health Fund to provide funding for programs aimed at improving health outcomes and restraining the rate of growth in private and public sector health care costs. (<i>§4002</i>)	(\$7.7 billion cost increase)**
Prevention	Increases access to preventive services by prohibiting new insurance plans from requiring cost-sharing for such services (<i>§1302</i>); and by increasing coverage of preventive services for Medicare and Medicaid beneficiaries. (<i>§4103–4108</i>) Invests in promotion of community preventive health activities through grants to state and local governments and NGOs for implementation, provision, and evaluation of preventive services. (<i>§4201-4204</i>) Provides for assistance, consultation, and evaluation tools as well as training for employer-based wellness programs via the CDC. (<i>§4303</i>)	(\$4 billion cost increase)
Patient-Centered Outcomes Research Institute	Created the nongovernmental, nonprofit Patient-Centered Outcomes Research Institute (PCORI) to conduct research on risks and benefits, effectiveness, and appropriateness of different medical treatments (excluding coverage rules or reimbursement), which could lead to decreases in low value, unnecessary or harmful care. (<i>§6301</i>)	(\$2 billion cost increase)
Independent Payment Advisory Board	Created the Independent Payment Advisory Board to recommend policies for slowing Medicare spending if the growth rate exceeds a legislatively-determined target growth rate (blend of CPI and CPI-Medical before 2018; GDP + 1% beginning in 2018). (<i>§3403; §10320</i>)	\$15.5 billion

*Savings estimates from Congressional Budget Office, March 20, 2010, Letter to Honorable Nancy Pelosi. <https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>

**The Middle Class Tax Relief and Job Creation Act reduced the funds allocated by the ACA by approximately \$5 billion over the first decade. The figure has been adjusted to account for the reduction but does not reflect sequestration cuts or funding diversions to other HHS programs.

Conclusion

The ACA policies aimed at transforming the quality, delivery system, and payment structure of health care will have long-term impacts, but it is unclear when the projected cost-savings of those policies will be realized. In 2012, health care spending grew by 3.7 percent, a record low pace for the fourth consecutive year.¹¹ Some analysts attribute the slowed growth in health care spending to the Great Recession, and argue that rapid growth in health care spending will likely return as the economy recovers.¹²

Others have suggested that changes to the health care system, including those made by the ACA, contributed to the slowed growth in spending.¹³ Analysis by the Kaiser Family Foundation and the Altarum Institute in April 2013 indicated that most (77 percent) of the recent decline in health spending growth can be attributed to changes in the broader economy, with the remaining 23 percent attributed to changes in the health care system such as increased cost sharing and changes in payment and delivery systems.¹⁴ Both organizations concluded that spending will increase as the economy recovers and that temporary increases are likely to occur as individuals previously uninsured gain coverage; however, these analysts consider the return of double-digit growth unlikely.¹⁵

Most recent data indicate that increases in health care spending are no longer on a downward trend but have returned to pre-recession rates. The Altarum Institute reported that health care spending grew by 6.7 percent in February 2014, the highest level since March 2007.¹⁶

The impact of the ACA on cost is not completely clear, especially considering the major implementation activity in 2014. The impact of the ACA's many provisions aimed at moderating costs will be measured and become clearer over the coming years.

Authors: Kersten Lausch, MPP; Erin Shigekawa, MPH; Daphna Stroumsa, MD, MPH; Ruth E. Tabak, MPH, MPP

¹ M. Chernew, K. Baicker, and Carina Martin. April 16, 2010. *Spillovers in Health Care Markets: Implications for Current Law Projections*. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/spillovereffects.pdf> (accessed 1/15/14).

² Congressional Budget Office. March 20, 2010. Letter to Honorable Nancy Pelosi. <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf> (accessed 1/15/14).

³ U.S. Department of Health and Human Services. N.d. *The Affordable Care Act and the Prevention and Public Health Fund Report to Congress for FY2012*. http://www.hhs.gov/open/recordsandreports/prevention/fy2012/aca_rpt_to_congress.pdf (accessed 1/15/14).

⁴ P.L. 111-148: The Patient Protection and Affordable Care Act. Section 4002: Prevention and Public Health Fund. 111th Congress. Enacted March 23, 2010. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf> (accessed 1/15/14).

⁵ P.L. 112-96: The Middle Class Tax Relief and Job Creation Act of 2012. Section 3205: Prevention and Public Health Fund. 112th Congress. Enacted February 22, 2012. <http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf> (accessed 1/15/14).

-
- ⁶ Centers for Disease Control and Prevention. N.d. *Budget Information, The Prevention and Public Health Fund*. http://www.cdc.gov/fmo/topic/budget%20Information/appropriations_budget_form_pdf/The-Prevention-and-Public-Health-Fund.pdf (accessed 1/15/14).
- ⁷ P.L. 113-76: Consolidated Appropriations Act. 113th Congress. Enacted January 17, 2014. <http://beta.congress.gov/bill/113th-congress/house-bill/3547> (accessed 4/11/14).
- ⁸ J. Selby. September 23, 2013. PCORI: Three Years of Progress and a Foundation for the Future. PCORI. <http://www.pcori.org/blog/pcori-three-years-of-progress-and-a-foundation-for-the-future/> (accessed 4/11/14).
- ⁹ J. Selby. January 13, 2014. PCORI General Session. <http://www.pcori.org/assets/2014/01/PCORI-Advisory-Panel-General-Session-Slide-Presentation-011314.pdf> (accessed 4/11/14).
- ¹⁰ Ibid.
- ¹¹ Centers for Medicare and Medicaid Services. N.d. *National Health Expenditures 2012 Highlights*. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf> (accessed 4/16/14).
- ¹² V. Fuchs. July 11, 2013. The Gross Domestic Product and Health Care Spending. *N Engl J Med* 369(2): 107–109.
- ¹³ D. Blumenthal, K. Stremikis, and D. Cutler. December 26, 2013. Health Care Spending—A Giant Slain or Sleeping?. *N Engl J Med* 369(26): 2551–2557.
- ¹⁴ Kaiser Family Foundation and Altarum Center for Sustainable Health Spending. April 22, 2013. *Assessing the Effects of the Economy on the Recent Slowdown in Health Spending*. <http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/> (accessed 4/17/14).
- ¹⁵ Ibid.
- ¹⁶ Altarum Center for Sustainable Health Spending. April 8, 2014. *Insights from Monthly National Health Expenditures Estimates through February 2014* (Ann Arbor, MI: Altarum Institute). http://altarum.org/sites/default/files/uploaded-related-files/CSHS-Spending-Brief_April%202014.pdf (accessed 4/17/14).