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Adding Up the Numbers

Understanding Medicare Savings in the Affordable Care Act

By Mark Merlis October 2010

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Understanding Medicare Savings in the Affordable Care Act

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CAP's Doing What Works project promotes government reform to efficiently allocate scarce resources and achieve greater results for the American people. This project specifically has three key objectives:

Eliminating or redesigning misguided spending programs and tax expenditures, focused on priority areas such as health care, energy, and education

Boosting government productivity by streamlining management and strengthening operations in the areas of human resources, information technology, and procurement

Building a foundation for smarter decision-making by enhancing transparency and performance measurement and evaluation

This paper is one in a series of reports examining government accountability and efficiency.

Introduction and summary

The comprehensive health care overhaul passed by Congress as the Affordable Care Act and then amended by the Reconciliation Act of 2010 includes changes in the Medicare program that are expected to reduce the federal deficit by $525 billion between now and 2019. Of this amount, about $424 billion comes from changes in coverage and payment rules. This includes limits on annual rate increases for hospitals and other providers that furnish health care to our nation's 46 million elderly and disabled Medicare beneficiaries. The Affordable Care Act, or ACA, also includes cuts in payments to Medicare Advantage plans, private organizations that serve beneficiaries as an alternative to the original Medicare program.

The remaining $100 billion comes from new revenue sources for the Medicare trust funds.[1] These include changes in the Medicare payroll taxes paid by high-income earners and new fees for drug manufacturers and importers.

Skeptics of ACA say that cuts in provider payments are too sharp and could over the long term lead to reduced access or quality of care for Medicare patients. In their view, Congress may eventually face pressure to rescind the cuts, causing much of the budgetary savings to evaporate. In contrast, those more optimistic about the new law contend there is enormous room for health care providers to improve the efficiency of medical care and that the Affordable Care Act will promote systemwide structural reforms that will generate even greater savings for Medicare and other payers than the official projections indicate.

The Doing What Works project at the Center for American Progress promotes government policies that deliver cost savings and more efficient use of taxpayer dollars, both of which the Affordable Care Act promises to deliver. That mission requires an honest appraisal of the reliability of data used to justify policies. This paper attempts such an appraisal, and is one in a series of reports that will track the implementation of monumental health care reform as it rolls out around the country.

This paper examines the total amount of Medicare savings from the Affordable Care Act by considering different ways of looking at the numbers and comparing ACA spending reductions to those in other major Medicare legislation, such as the Balanced Budget Act of 1997 and two Omnibus Budget Reconciliation Acts in the early 1990s. It then looks at the debate over whether the spending cuts are real and sustainable over time.

As this paper will demonstrate, there is good reason to believe that the new health care law significantly improves the medium-term fiscal position of Medicare, and points the way toward more significant changes in our health care system over the long term—changes that will improve the efficiency and quality of care in the 21st century.

How big are the savings?

The Congressional Budget Office estimates that ACA provisions specifically affecting Medicare will reduce the federal deficit by about $525 billion over the 10-year period from 2010 to 2019.[2] The Obama administration cites a higher total of $575 billion in Medicare savings, reflecting estimates by the Office of The Actuary and the Centers for Medicare and Medicaid Services, or CMS.[3] The different totals reflect different ideas about the potential effect of specific provisions as well as different estimates of the "baseline"—what would have been spent on Medicare under the law as it existed before the passage of ACA.

TABLE 1
How Congress counts the savings

Deficit reduction from ACA Medicare provisions, 2010–2019 (in billions of dollars)

Spending changes	$ billions
General provider payment reductions	-221.9
Medicare Advantage payment reductions	-206
All other changes (net spending increase)	3.5
Total changes in spending	-424.4
Revenue changes	-100.4
Total deficit reduction	-524.8

Source: Author's analysis of CBO and JCT estimates.

Because CBO and CMS present their numbers differently, the exact points on which their estimates differ cannot be ascertained. Except as noted, this paper uses CBO estimates and, for revenue provisions, estimates by the Joint Committee on Taxation because these are the numbers Congress relied on when it passed the legislation. (see Table 1)

Spending cuts in the ACA and other Medicare legislation

The spending reductions in ACA are comparable to those under three other major laws enacted since 1990 that included significant reductions in Medicare spending. All of the savings estimates shown in Table 2 are those provided by CBO at the time of the legislation's enactment. They are calculated relative to the CBO baseline—that is, CBO's estimate of what would have been spent without the legislation. These baselines and the savings estimates for each bill reflect outlays for services, without offsetting revenues such as premiums and payroll taxes and without Medicare administrative costs.

Until recently, CBO used only a five-year window for baselines and savings estimates; 10-year estimates are available only for the Balanced Budget Act of 1997

and the ACA. In addition, CBO estimates that ACA savings don't really begin until Fiscal Year 2011, which begins in October 2010. (Indeed, there is actually a slight increase in spending for FY 2010.) A nine-year estimate, shown in the last line of Table 2, provides a more meaningful comparison with previous bills.

TABLE 2

Measuring savings against the baselines

CBO Medicare baselines and estimated spending cuts in major legislation (in billions of dollars)

Bill and year passed	Period of estimate	Baseline Medicare spending for period	Net spending reductions	Savings as percent of baseline
Omnibus Budget Reconciliation Act of 1990	1991–1995	$731	$43	5.9%
Omnibus Budget Reconciliation Act of 1993	1994–1998	$1,059	$56	5.3%
Balanced Budget Act of 1997	1998–2007	$3,367	$306	9.1%
Affordable Care Act	2010–2019	$6,192	$424	6.9%
Affordable Care Act, excluding 2010	2011–2019	$5,664	$427	7.5%

Source: CBO January baseline estimates for 1993, 1997, and 2010, and July baseline for 1990. Spending reduction estimates for 1990–1997 from House Committee on Ways and Means, ***2004 Green Book: Background Material and Data on the Programs within the Jurisdiction of the Committee on Ways and Means.***

In nominal dollars (not accounting for inflation) Medicare savings under ACA are larger than those from the other bills. As a percent of the baseline, however, they are smaller than those originally projected under the Balanced Budget Act, and only slightly larger than those under the two earlier Omnibus Budget Reconciliation Acts of 1990 and 1993. All of these savings numbers reflect estimates made at the time each bill was enacted.

But it is important to note that for two reasons it is rarely possible to ascertain whether changes in Medicare law, which are intended to reduce spending, actually produce the projected savings. First, many factors other than legislation, such as changes in the behavior and health of Medicare patients and in medical practice, affect program spending trends. Isolating the effects of a rule change from changing circumstances after the rule change is difficult.

Second, each round of legislative changes was followed by another set of changes within a year or two as Congress sought further program savings. The new changes are then scored as achieving savings relative to a baseline that already assumes not-yet-realized savings from previous laws.

The ACA and total Medicare spending

There are at least two ways of considering the long-range effects of ACA's Medicare provisions. One is to look at projected Medicare spending as a percentage of gross domestic product, or GDP—the total market value of goods and services produced in our economy in a given year. This is the most useful way of measuring the overall burden of Medicare on society. The second, discussed in the next section, is to look at the effects on the Medicare trust funds.

But first, the GDP analysis. Figure 1 compares Medicare spending estimates from the 2009 and 2010 reports of the Medicare Trustees comprised of Michael J. Astrue, the Commissioner of Social Security, and the Secretaries of the Departments of Treasury, Health and Human Services, and Labor. The 2010 report includes the effects of changes because of ACA. The Trustees rely on estimates by the CMS Actuary—estimates that differ from CBO's for the 2010–2019 period. CMS figures are used here because CBO does not provide formal estimates beyond 2020.

As the table indicates, the difference between the pre-ACA and post-ACA spending estimates grows steadily larger as the years go on. This is because the pre-ACA estimate assumes that spending per Medicare beneficiary will grow considerably faster than the rest of the economy. The Affordable Care Act, however, includes mechanisms designed to limit allowable growth in spending per beneficiary. Total Medicare spending as a percent of GDP still rises because of the increase in the Medicare population as Baby Boomers retire. But the projected reduction in Medicare spending from ACA provisions amounts to 1.7 percent of GDP by 2035. This means that Medicare's share of total output will be 24 percent smaller than it would have been without ACA.

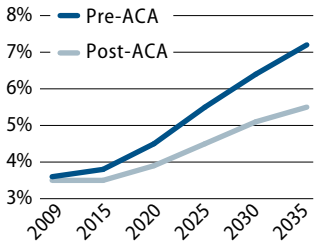
The Trustees' report continues the line out to 2080, by which time post-ACA spending is projected to be just half of what it would have been without the ACA changes. As the CMS Actuary notes in an appendix to the 2010 report, it is implausible that the spending restraints imposed by ACA will continue without modification for 70 years.[4] But of course it is just as implausible that spending will rise at the current rate forever, as the pre-ACA estimates suppose.

The issue of very long-range estimates will be considered at the end of this paper.

FIGURE 1

Impact of ACA on medicare spending as a percent of our economy

Intermediate estimate of total Medicare spending as a percent of GDP



Source: Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2009 and 2010 *Annual Report.*

Affordable Care Act and the Medicare trust funds

Medicare has two trust funds. The Hospital Insurance, or HI trust fund covers Medicare Part A benefits, which include inpatient hospital services and some posthospital care. The Supplemental Medical Insurance, or SMI trust fund covers Medicare Part B, including doctors' services and outpatient care and the Medicare Part D prescription drug program.[5] The HI trust fund receives the proceeds from the HI payroll tax on employees and employers and some other revenues, and then uses this income to pay hospitals and other Part A health care providers. When these Medicare payroll tax revenues exceed outlays, the trust fund buys government securities, which are held in the fund to be cashed in at some future date if outlays exceed revenues.

In contrast, the SMI trust fund draws its revenues from beneficiary premiums and general federal funds, but spends the money as fast as it gets it. This trust fund never accumulates a surplus or a deficit, as the annual draw on federal funds is equal to spending minus premium collections. Because the SMI fund is basically an accounting mechanism, policymakers usually focus on the HI fund.

Each year, the Medicare Trustees (all of whom today are Obama administration officials because private slots on the Board are vacant) issue a report on the financial condition of the various trust funds. The 2009 report said that the HI fund had assets of $326 billion at the end of 2007. In 2008, however, the fund spent more than it took in. The Trustees projected that this would be true for each subsequent year, until the fund was exhausted in 2017. After that, Part A benefit payments would have to be limited to the amount of payroll tax income or Congress would have to act to make up the shortfalls.

The 2010 Trustees' report, issued on August 5, 2010, includes the effects of ACA spending and revenue changes. For the next few years, HI spending will continue to outpace revenues. But this turns around in 2014. Starting in that year and continuing for several more years, the trust fund will see a surplus. Then, beginning in 2020, spending will again begin to exceed revenues. The HI trust fund then would have to cash in assets and would be exhausted in 2029.

This is 12 years later than the projection in the 2009 Trustees' report. Yet the HI fund's operations from 2020 onward would be funded by steadily larger draws upon its assets. As the fund cashes in its U.S. government securities, the federal government must come up with the money through taxes or borrowing.

The upshot according to the Medicare Trustees is that ACA did not permanently fix the HI trust fund problem but certainly made a solution much easier. Currently, employers and employees each pay a 1.45 percent HI payroll tax. Before ACA, keeping the HI trust fund solvent for the next 50 years would have required that the payroll tax nearly double to 2.87 percent for employers and employees. The Trustees' report for 2010 estimates that raising the tax to 1.77 percent would keep the fund solvent through 2059.[6]

Are the savings real?

ACA skeptics contend that the Medicare savings provided by the ACA are unlikely to be realized. These critics of the legislation raise several arguments, among them:

- Health care providers cannot achieve the savings required by the constraints on Medicare payment rates without compromising access and quality of care, which means Congress will eventually override these payment constraints.

- The Independent Payment Advisory Board, established under the ACA as a backup mechanism to limit spending growth, is empowered only to recommend further payment reductions, which only compounds the problem.

- ACA does not address the problem of Medicare physician payment; solving this problem could wipe out much of the promised savings.

The following discussion considers each of these points in turn.

Are the required efficiency gains possible?

ACA limits annual increases in payment rates for most types of providers other than physicians. The updated calculation will begin with an estimate of inflation in "input costs," or the costs of wages and other goods and services that health care providers must purchase to provide care to their Medicare patients. This will then be reduced by a productivity adjustment based on the 10-year average annual increase in economywide productivity. For payments through 2019, the law specifies additional percentage cuts in payment increases. These cuts vary by provider type and year. Any Medicare payment rate increases below the level of inflation mean that hospitals and other care providers will need to steadily improve their efficiency.

The CMS Actuary, Richard Foster, and other analysts express skepticism about the ability of providers to meet ACA targets. Foster's statement of opinion in the 2010 Trustees' report puts it this way:

> *[T]he annual price updates for most categories of non-physician health services will be adjusted downward each year by the growth in economy-wide productivity. The best available evidence indicates that most health care providers cannot improve their productivity to this degree—or even approach such a level—as a result of the labor-intensive nature of these services.*[7]

There are at least two potential problems with this statement. The first is that it suggests greater consensus than exists about the ability of health care providers to improve their productivity. The second, more important one, is the assumption that living within ACA limits requires improvements in productivity in the ordinary sense of the term.

Improving productivity usually means using fewer inputs (hours of labor, gallons of fuel, or whatever else is needed) to produce a given output. If it once took a worker two hours to produce a widget and now a worker can do it in one hour (without other costs having gone up), then productivity has doubled. These improvements are easy to quantify when the output is a clear unit like one widget.

But what is the output to be measured in health care? A day in the hospital? A successfully completed hip replacement, including follow-up care? A patient with improved quality of life? This problem has been debated for decades, and there is very little agreement on a solution. Indeed, the Department of Labor's Bureau of Labor Statistics, the principal source of productivity data, does not even produce estimates of productivity growth for most health care sectors.[8]

If it is so hard to measure health sector productivity, then why do ACA payment rules require productivity improvements? The answer is that they don't. Economywide productivity gains are being used as a benchmark for improvements in efficiency. The Medicare Payment Advisory Commission, or MedPAC, which has long advocated a productivity adjustment for payment updates, explains the rationale this way:

> *Competitive markets demand continual improvements in productivity from workers and firms. These workers and firms pay the taxes used to finance Medicare. Medicare's payment systems should exert the same pressure on providers of health services. The Commission begins its deliberations with the expecta-*

tion that Medicare should benefit from productivity gains in the economy at large (the 10-year average of productivity gains in the general economy, currently 1.3 percent). This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay the taxes that fund Medicare. But the Commission may alter that expectation depending on the circumstances of a given set of providers in a given year.[9]

Today, hospitals are paid a flat amount for care of a patient with a particular diagnosis throughout an inpatient stay—regardless of the number of days of care or what services are performed each day. Home health agencies are paid for 60-day episodes of care for a patient with a particular condition and need for care—again regardless of how many services are performed during that period.

The point of these prospective payment systems is not, for example, to make hospitals find a less labor-intensive way of performing a single test or procedure. Instead, these bundled payments are meant to create pressure for hospitals to modify the quantity or mix of individual services they furnish. Hospitals must continually look for more efficient ways of providing the overall care the patient needs without compromising quality. If health care providers are instead given rate increases that reflect cost increases for their intermediate outputs (such as a test or a day of care) they will never have any incentive to improve their efficiency in providing the ultimate output of improved patient health.

But what happens if some care providers cannot reduce their costs for Medicare patients to the target levels set by ACA? One common claim is that they will make up their losses by raising charges to other payers, such as private health insurers. Economic theory suggests that such "cost shifting" is feasible only if the provider has enough bargaining power to command higher rates. And if health care providers have this market power then they will demand higher rates from private insurers no matter whether they are losing money on Medicare or other patients. Research by MedPAC shows that providers who are losing money under Medicare often have robust profits from private payers; these profits give them a cushion that reduces their incentive to treat Medicare patients more efficiently. MedPAC concludes that raising Medicare rates would not solve the problem of rising private premiums.[10]

Another possibility is that some health care providers who are especially dependent on Medicare will have difficulty operating. The CMS Actuary contends that as many as 15 percent of Medicare Part A providers would become unprofitable within 10 years and might end Medicare participation or go out of business.[11]

Whether this is undesirable is debatable. Community hospitals, for example, were operating at about two-thirds capacity in 2008.[12] Obviously it will be important to monitor trends and make adjustments as necessary to address problems related to access to care that may emerge. But Congress can fine-tune Medicare payment restraints without abandoning them.

Undoubtedly Congress will face pressure for relief, as it always has, from individual health care providers and provider groups most affected by payment constraints. But any adjustments will be subject to "pay-go" rules adopted by Congress in January 2010, which require that most legislation that could increase the federal budget deficit, either by raising spending or cutting taxes, must be paid for with offsetting measures that cut spending in other areas or raise revenues. Congress could override these rules as it has done in the past. But given current concerns about the deficit, it seems unlikely that Congress will casually overturn ACA limits unless there is evidence of widespread deterioration in access or quality of care.

Independent Payment Advisory Board

Beginning in 2014, this new board will recommend spending cuts for the following year if projected growth in per capita Medicare spending exceeds specified targets in ACA. The recommendations are binding unless Congress adopts other cuts that bring spending within the targets. Targets are initially based on the average of growth in the consumer price index for all urban consumers, or CPI-U, and growth in the CPI medical component, which measures changes in prices for various medical services.

Beginning with 2018, the target is equal to per capita growth in GDP plus 1 percentage point. Recommended spending cuts may not affect benefits, eligibility, or beneficiary premiums or cost sharing. And until 2020 cuts may not affect payment rates for any of the classes of health care providers subject to the productivity-related cuts described earlier.

Regardless of the targets, the total amount that can be cut in any given year is limited; the annual limit starts at 0.5 percent of program spending for 2015, rising to 1.5 percent by 2018 and for later years. Both CBO and CMS project that Independent Payment Advisory Board-directed cuts through 2019 will be fairly small because other ACA provisions will produce most of the required savings. From 2020 on, CMS projects that no action by the new board will be required because the provider payment limits will achieve all the needed savings.

The Independent Payment Advisory Board is, in effect, a failsafe savings mechanism if other savings provisions fail to hold growth to target levels. The need for action by IPAB is greater before 2018 because, as noted earlier, both CBO and CMS project that other savings in the ACA will be insufficient to meet the targets. If this prediction proves accurate, the IPAB would need to find cuts totaling $16 billion in 2015–2019. After 2019, CMS projects that ACA limits on health care provider payment increases should be sufficient to meet the targets. IPAB would then need to intervene only if there were some unanticipated growth in per capita spending because of changes in volume or practice patterns.

Some health care analysts contend that IPAB's effectiveness will be limited because it may only recommend changes in provider payment rates or methods, not in the scope of benefits covered by Medicare or the cost sharing paid by beneficiaries. In this view, IPAB might just extend to other types of providers the failed experience of the so-called sustainable growth rate, or SGR limits adopted for physician payments in 1997. Under the SGR system discussed in the next section, increases in volume and intensity of services delivered by physicians would have triggered draconian automatic payment rate cuts if Congress had not intervened.[13] If the same thing happened under the ACA's expenditure target system, wouldn't Congress intervene again?

This assumes, however, that the only measures available to IPAB are across-the-board cuts that, like the SGR limits, penalize all providers in a category for overspending by a few. The potential advantage of IPAB is that, theoretically freed from political pressures, it might be able to correct misplaced incentives that reward overuse of some services or target specific groups of providers who are arguably overpaid.

To give a single example: MedPAC reports that freestanding home health agencies, which provide nursing and other services to beneficiaries after a hospital discharge, had an average Medicare margin (surplus of revenue over cost) of 17.4 percent in 2008.[14] The ACA payment changes will reduce home health spending in 2019 to about 20 percent below the pre-ACA projected level, essentially wiping out the industrywide surplus and requiring agencies to improve efficiency simply to break even. It might seem that no more can be squeezed out of home health spending without compromising quality. But the MedPAC data show that the top 20 percent of home health agencies had margins of 36 percent, twice the average in the home health industry overall.

It is not certain whether these top 20 percent of home health agencies are more efficient or whether they have found ways of exploiting problems with the existing Medicare payment system, such as inaccurate estimates of the costs of treating different kinds of patients. MedPAC has a long history of researching problems of this kind and recommending modifications in Medicare payment rules but it has never had any authority to implement its proposals. In contrast, IPAB's recommendations for correcting problems in the distribution of spending would be binding on CMS unless overridden by Congress.

The physician payment problem

Finally, there's the physician payment problem, which some observers claim will devour much of the savings anticipated under ACA. Under current Medicare rules that are intended to restrain growth in spending, Medicare payments to physicians are subject to automatic cuts when aggregate physician spending exceeds the SGR limits.[15] Since 2003, Congress has repeatedly intervened to prevent rate cuts in the short term, but it has never changed the formulas that dictate these cuts. Each time Congress has set the fee increase, it has specified that fee updates for later years should be computed as if it had never acted.

As a result, under current law physicians' fees under Medicare are scheduled to be cut by 23 percent in December 2010 with further reductions to take effect in coming years. No one believes that Congress will allow a cut of this size. But a proposed "doc fix" that would override these cuts could add $300 billion or more to federal spending over the 10 years from 2010 to 2020.[16]

ACA did not create this problem and did not fix it. The savings achieved by ACA are almost entirely in nonphysician services and will not be affected by any resolution of the physician payment issue. But some analysts contend that the current law baseline against which ACA savings are measured is artificially low because it is inevitable that Congress will reverse the physician payment cuts. The effect of using a modified baseline is illustrated in Table 3.

TABLE 3

The consequences of a "doc fix" on Medicare spending

Effect of ACA and physician payment policy on Medicare spending as a percent of GDP in 2020

	Current law	Assuming reversal of physician cuts
Pre-ACA spending as percent of GDP	3.8%	4.2%
Spending after ACA savings	3.2%	3.6%
Savings as percent of baseline	15.0%	13.6%

Source: Office of the Actuary, CMS, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers." Physician fees are allowed to go up 2 percent a year.

Adding an assumed reversal of the physician payment cuts to the baseline raises total estimated pre-ACA Medicare spending to 4.2 percent of GDP in 2020, up from 3.8 percent under a baseline that assumes all the cuts will take effect. The post-ACA numbers are similarly affected, jumping to 3.6 percent from 3.2 percent. Even with the adjusted baseline, however, the ACA still reduces spending in 2020 by almost 14 percent.

So even in this scenario, the "doc fix" would not bend the cost curve in the wrong direction. In any case, it is by no means certain that Congress will undertake a complete reversal of current law limits on physician payment rates. Again, congressional "pay-go" rules would require Congress to find other savings or new revenues if it wishes to increase physician payments.[17]

In the near term, Congress is likely to go on adjusting physician rates a year at a time rather than adopt a sweeping, hugely costly overhaul. And some analysts believe that temporary adjustments—kicking the can down the road—might actually be preferable to a complete reform.[18] In this view, a continued threat of future payment cuts could help induce physicians to cooperate on some of the payment or delivery reforms contained in the ACA, such as accountable care organizations, which will be rewarded for improving the efficiency with which care is delivered.

Conclusion

The Accountable Care Act significantly improves the medium-range fiscal outlook for the Medicare program. The solvency of the Hospital Insurance trust fund is extended by 12 years (or 11 even under the CMS Actuary's alternative scenario) and could be extended to 2059 with a fairly small and sustainable adjustment in the HI payroll tax.

Growth in Medicare Part B spending is potentially a larger problem. The failed SGR system of payment limits will need to be modified or replaced by other reforms that can counter the incentives for unlimited volume increases encouraged by the existing fee-for-service payment system. These reforms will take time to develop, but some analysts contend that delivery system innovations and structural improvements such as use of electronic health records can eventually "bend the cost curve."[19] The blunt instrument of across-the-board payment restraints can gradually give way to broader reforms in the way care is organized and delivered.

Obviously, there is going to be a period of sharply increased spending simply because of the number of retirees entering the Medicare program in the coming years. But many other industrialized countries have already faced similar demographic pressures and have adjusted to them without abandoning fundamental protections for their citizens.

Some people believe that we should make fundamental changes in Medicare entitlement today on the basis of projections of future spending as far forward as 2080. The Medicare Trustees are required to go through the exercise of developing these very long-range estimates of Medicare program solvency. But the projections consist simply of holding a pencil down and tracing a line that continues past experience into the indefinite future.

No one can say with any confidence what Medicare beneficiaries' health needs, or the medical care system that meets those needs, will be like even 20 years from now, much less 70 years from now. One need only imagine what projections of

medical costs in 2010 might have been offered in 1940, before the arrival of antibiotics, open heart surgery, or kidney dialysis.

The history of Medicare for almost 50 years now has been one of predictions of imminent disaster and last-minute rescues. The Accountable Care Act has once again rescued the program for a while. What will be important now will be for Medicare, in concert with other health insurers and public payers, to work toward the fundamental payment-and-delivery reforms that will be needed to make the entire medical care system—not just one payment stream—sustainable over time.

Appendix: Details of ACA Medicare savings

This appendix describes the key provisions of the Affordable Care Act that affect Medicare spending and revenues. Table 4 shows the major components of ACA Medicare savings for fiscal years 2010–2019. Total Medicare benefit spending is reduced by $424 billion, and revenues increase by $100 billion.

The following discussion examines each of these categories in turn.

TABLE 4
Components of ACA Medicare savings, 2010–2019 (in billions of dollars)

Spending changes	
General provider payment reductions	-221.9
Medicare Advantage payment reductions	-206
Independent Payment Advisory Board	-15.5
Eliminate Medicare Improvement Fund	-20.7
Part D prescription drug coverage changes (net increase)	34.9
Miscellaneous payment and coverage changes (net increase)	4.8
Total changes in spending	-424.4
Revenue changes	
Fee on manufacturers and importers of brand-$ name drugs	-27
Hospital Insurance tax for high-$ income taxpayers	-86.8
Part B premiums (net decrease in receipts)	13.4
Total changes in revenues	-100.4
Deficit reduction	-524.8
Deficit reduction including Medicare unearned income contribution for high-income taxpayers	-648.2

Source: Author's analysis of CBO and JCT estimates.

General provider payment reductions

In addition to the overall constraints on payment updates discussed earlier, this category includes two other payment reductions affecting entire categories of providers. First, payments to disproportionate share hospitals—those serving large numbers of low-income people—are cut by 75 percent, with the cuts partially offset by payments to hospitals based on their actual uncompensated care load. The formula assumes that aggregate uncompensated care costs will drop in proportion to the drop in the uninsured population resulting from ACA coverage provisions.

Second, payments to home health agencies have been "rebased." All of the rates are to be recalculated using newer data, resulting in overall reductions. Many other ACA provisions increase or decrease payments for specific services or subgroups of providers. These are included in the "miscellaneous" category in Table 5.

Independent Payment Advisory Board

As discussed earlier, the Board will need to find $15.5 billion in savings beyond those specified in ACA to meet the spending targets through 2019.

Medicare Advantage

Private Medicare Advantage plans submit bids to provide core Medicare benefits. If the bid is less than a fixed benchmark for the area served by the plan, then some

of the difference is shared with plan enrollees in the form of supplemental benefits. Many plans have been able to offer extra benefits only because the benchmark for their area has been set well above what Medicare would have spent to provide services under the traditional Medicare fee-for-service program.

Under ACA, benchmarks for Medicare Advantage plans will be brought closer to (or, in some areas, below) fee-for-service levels.[20] This will mean reductions in supplemental benefits and reduced incentives for beneficiaries to join these federally subsidized private-sector plans. CBO projects that Medicare Advantage enrollment in 2019 will be 14 percent below the 2009 level.

Medicare beneficiaries who remain in the plans will still be getting a good deal. The CBO estimates that Medicare Advantage enrollees whose plans operate efficiently, providing basic Medicare services for less than the cost of serving a comparable population in traditional Medicare, will receive extra benefits worth $79 a month—nearly $1,000 a year—in 2019. Even enrollees in private plans that are less efficient than traditional Medicare will still get extra benefits worth $48 a month in 2019.[21]

Part D prescription drug coverage

ACA reduces Medicare beneficiary liability in the so-called "doughnut hole" coverage gap for prescription drugs, saving participants $43 billion over 10 years, and includes a number of benefit improvements. These are partially offset by reduced subsidies for higher-income enrollees. Still, ACA provisions overall increase Part D spending by $35 billion.

Miscellaneous

This category includes a variety of other measures—some that raise costs, such as improved coverage of preventive services, and some that lower costs, such as a program to reduce hospital readmissions. CBO also scores some savings for new delivery or payment models included in the ACA, such as accountable care organizations and bundled payments. The CMS Actuary projects no savings from these measures.

The largest item in the "miscellaneous" group is the elimination of a fund established by 2008 legislation that was to be used "to make improvements under the original fee-for-service program under parts A and B." The fund was supposed to begin operating in 2014 with a four-year appropriation of $21 billion. ACA zeroes this out.

New revenues

The ACA includes two provisions that increase trust fund revenues. The first is an increase in the Health Insurance trust fund payroll tax for high-income earners. All workers pay an HI tax of 1.45 percent of earned income. Now those with incomes greater than $200,000 ($250,000 for joint returns) will pay an extra 0.9 percent of earned income.

The second item is a fee imposed on brand-name drug manufacturers and importers. The law sets a fixed aggregate amount of fees to be collected in each year beginning in 2011, with the share of the fees paid by each manufacturer or importer based on its share of total brand-name sales to Medicare Part D prescription drug plans, to Medicare and Medicaid directly, and to Department of Defense and veterans programs. Proceeds go into the Part B trust fund.[22]

These two gains in revenues are partially offset by a reduction in net beneficiary Medicare premium payments. The Part B premium is set at 25 percent of Medicare Part B spending. Cuts in that spending mean cuts in the premium—saving beneficiaries an estimated $38 billion over 10 years. But higher-income beneficiaries will temporarily pay a higher premium than under prior law. As a result, the net reduction in Part B revenues will be $13 billion.

A third tax provision in ACA is an "unearned income Medicare contribution." Higher-income taxpayers will pay 3.8 percent of investment income. Despite the Medicare label, however, the proceeds from these payments will go into the general treasury rather than into the Medicare trust funds. For this reason, the CMS actuary argues that it should not be counted toward total Medicare savings, but should be classed with other non-Medicare revenue provisions in ACA. If the tax was counted as Medicare revenue, then total Medicare savings would rise to $648 billion over 10 years.

Endnotes

1 Author's analysis, based on Congressional Budget Office estimates provided in March 20, 2010, letter from CBO Director Douglas Elmendorf to Speaker Pelosi, and Joint Committee on Taxation estimates for the ACA (March 11, 2010) and the Reconciliation Act (March 20, 2010). The revenue total does not include one Medicare-related tax provision that does not contribute to the trust funds.

2 This figure does not include some indirect effects on other programs and some provisions, such as anti-fraud measures, that jointly affect Medicare, Medicaid, and the Children's Health Insurance Program.

3 Office of the Actuary, Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (Department of Health and Human Services, April 22, 2010).

4 Richard S. Foster, "Statement of Actuarial Opinion," *2010 Medicare Trustees' Report*.

5 Part C is the Medicare Advantage program; Medicare payments to MA plans are drawn from both funds.

6 The CMS Actuary's more pessimistic alternative scenario indicates that the tax would need to go to 2.08 percent, still a dramatic improvement over the pre-ACA figure. Office of the Actuary, Centers for Medicare and Medicaid Services, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers* (Department of Health and Human Services, August 5, 2010).

7 Foster, "Statement of Actuarial Opinion."

8 The two exceptions are medical laboratories and diagnostic imaging centers, which produce easily defined widgets. Productivity growth for these sectors far outpaced that of the total economy in 1987–2008. One Bureau of Labor Statistics paper did estimate health sector productivity and found negative productivity growth; the authors note that a negative estimate is generally an indication that there is something wrong with the output measure. Michael J. Harper, Bhavani Khandrika, Randal Kinoshita, and Steven Rosenthal, "Nonmanufacturing industry contributions to multifactor productivity, 1987–2006," *Monthly Labor Review*, June 2010.

9 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (March 2010).

10 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (March 2009).

11 Office of the Actuary, CMS, *Estimated Financial Effects*.

12 American Hospital Association, "Chartbook: Trends Affecting Hospitals and Health Systems," available at http://www.aha.org/aha/research-and-trends/chartbook/index.html.

13 See, for example, James C. Capretta, "The Independent Payment Advisory Board and Health Care Price Controls," *Kaiser Health News,* May 6, 2010.

14 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (March 2009).

15 For an overview, see Mark Merlis, "Health Policy Brief: Paying Physicians for Medicare Services," *Health Affairs*, June 25, 2010.

16 Congressional Budget Office, *Estimate of Changes in Net Federal Outlays from Alternative Proposals for Changing Physician Payment Rates in Medicare* (April 30, 2010).

17 The rules allow for a short-term physician payment increase but not for permanent relaxation of the SGR limits.

18 Henry J. Aaron, "The SGR for Physician Payment—An Indispensable Abomination," *New England Journal of Medicine*, 363 (5) (2010): 403–405.

19 David M. Cutler, Karen Davis, and Kristof Stremikis, "The Impact of Health Reform on Health System Spending" (Center for American Progress and The Commonwealth Fund, May 2010).

20 The fee-for-service amounts used in the formulas are themselves reduced by the general provider payment limits; this effect accounts for about one-third of the MA payment reductions.

21 Congressional Budget Office, *Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies for Extra Benefits Not Covered by Medicare Under Current Law and Under Reconciliation Legislation Combined with H.R. 3590 as Passed by the Senate* (March 19, 2010).

22 The CMS notes that Part B is already fully funded by other provisions of law; this provision reduces the deficit but, in trust fund terms, will create an anomalous unspendable surplus that will require some action by Congress.

About the author

Mark Merlis is an independent health policy analyst specializing in insurance and health financing issues.

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