



# IN PERSPECTIVE:

A CLOSER LOOK AT HOW THE AFFORDABLE CARE ACT HELPS EVERYONE

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## Lower Costs, Better Care: Medicare Cost Savings in the Affordable Care Act

Throughout the last year, a great deal of fuss has been made about cuts in the Medicare program that were included in the Patient Protection and Affordable Care Act (Affordable Care Act)—the comprehensive health reform law enacted earlier this year. It is important to know that these Medicare “cuts” are actually cost savings. They do not come from across-the-board reductions in benefits or from reductions in payments. The savings come from making Medicare work better by improving the way health care providers deliver care, modernizing how Medicare pays for those services, and eliminating waste, fraud, and abuse. (See “Medicare Physician Payments” on page 2 for clarification of the pending physician payment reductions.)

These targeted changes save \$418 billion over 10 years. This number seems huge, but it is important to put the magnitude of the savings in perspective by looking at overall spending in the Medicare program, as well as previous actions taken by Congress to address Medicare spending. For decades, the long-term sustainability of Medicare has been called into question. Congress has made changes to the program to keep spending in check in order to ensure that Medicare is around for future generations. The Affordable Care Act is no different: Through it, the financial outlook of the program is strengthened. And these savings allow for improved benefits and reduced out-of-pocket costs for beneficiaries.

## Medicare Physician Payments

Many people with Medicare have heard that their doctors are facing a substantial decrease in their Medicare payments. This decrease has been associated with health reform, but it is not related. In fact, the Affordable Care Act provides a 10 percent increase in Medicare payments for primary care providers.

The problem with doctors' payments and Medicare stems from a payment mechanism for doctors called the sustainable growth rate (SGR) enacted by Congress in 1997. After a few years, it became evident that the payment formula was flawed and was leading to steep reductions in Medicare's payments to doctors. In response, Congress has delayed these reductions from happening almost every year for the last seven years. Unfortunately, Congress has not replaced the formula with a new one. As a result, doctors now face a more than 20 percent payment reduction if Congress does not act. This year, Congress has provided short-term delays, which means that no doctors have experienced a reduction in Medicare payments in 2010. Congress must act again before November to delay the pending reduction for a longer period, or it must enact a permanent solution to this problem by creating a new physician payment formula to replace the current formula.

## Improving Medicare's Financial Outlook

Technological advances in health care services have caused care to become more expensive, and as a result, Medicare spending continues to increase. To ensure the sustainability of the program, it is necessary to make changes that improve and modernize the way services are paid for. In 2009, the Medicare Trustees estimated that the Medicare trust fund would be insolvent by 2017, meaning that after that date, the trust fund wouldn't have sufficient money to cover all of Medicare's estimated costs. In order to extend the life of the trust fund and to improve benefits for people with Medicare, the Affordable Care Act makes carefully targeted changes to the program to achieve \$418 billion in savings between now and 2019.<sup>1</sup> These changes extend the life of the Medicare trust fund by 12 years to 2029. (See "What Is the Medicare Trust Fund?" on page 3 to learn more about the Medicare trust fund.)

While \$418 billion over 10 years is a considerable spending reduction, it is important to understand that the savings are only a small amount compared to the total spending that will occur in the program over the same period of time. Over the next 10 years, Medicare will still spend about \$6.7 trillion (down from a projected \$7.1 trillion before the law was passed).<sup>2</sup>

While the annual growth in spending will decrease from 6.8 percent to 5.5 percent, the program's spending will still grow by more than 5 percent per year over the next 10 years. In other words, the Medicare program will spend more in 10 years than it does now (the rate of growth will just be slower), so it will continue to be able to meet the needs of today's and future beneficiaries.

Historically, spending reductions are not unusual and compared to other legislation, the reductions in the Affordable Care Act are modest.<sup>3</sup> For example, in 1997, faced with a forecast that the Medicare trust fund would become insolvent by 2001, Congress enacted substantial changes to the Medicare program, which were estimated to reduce future Medicare spending by 12 percent over 10 years.<sup>4</sup> By contrast, the Affordable Care Act is projected to reduce Medicare spending by about 5 to 7 percent over 10 years.

## What Is the Medicare Trust Fund?

The Medicare program consists of four distinct parts. Medicare Part A covers inpatient services, such as hospital and skilled nursing care. Medicare Part B covers outpatient services, including doctors and physical therapists. Medicare Part C (also known as Medicare Advantage) allows people with Medicare to receive their inpatient and outpatient coverage through private insurance plans. Medicare Part D is the prescription drug program administered through private insurance companies.

Medicare Part A is funded primarily through a dedicated payroll tax paid by employees and employers. The money generated through the payroll tax is credited to the Medicare Part A trust fund (also known as the Hospital Insurance or HI trust fund). Part B also has a trust fund, but it is financed by premiums and general revenues.

Every year, the Medicare Trustees project how many years the Part A trust fund will last before having inadequate funds to cover all benefits. The date of exhaustion has varied substantially, from as early as 1972 in the 1970 report to as late as 2030 in the 2002 report. As health care becomes more expensive, Medicare spends more money. Additionally, during difficult economic times, the amount of the payroll tax coming into the trust fund is lower, which means the trust fund is taking in less money. With revenues dropping and costs going up, the trust fund will experience a shortfall. That is why Congress acts periodically to either increase revenue, decrease expenditures, or some combination of both. As discussed in this report, the Affordable Care Act slows Medicare's rate of growth. It also increases the payroll tax for people earning more than \$200,000 for individuals or \$250,000 for couples from the current 1.45 percent to 2.35 percent.

## Achieving Cost Savings

So how are these cost savings in Medicare achieved? First of all, it's important to know that the savings in Medicare are not generated by reducing coverage of Medicare's guaranteed benefits. Guaranteed benefits will remain the same for every beneficiary. The savings are achieved by giving health care providers incentives to work together to provide high-quality, efficient care and by eliminating waste, fraud, and abuse. These measures not only save money, but they improve care for beneficiaries.

### ■ Paying for High-Quality Care

Among the ways the health reform law begins to rein in unnecessary spending while also improving the care beneficiaries receive is by encouraging hospitals to prevent avoidable readmissions and hospital-acquired conditions. Once these changes are fully implemented, they will save the Medicare program more than \$11 billion.

Sometimes it is necessary for a patient to be readmitted to the hospital shortly after being discharged—for example, if the patient must have multiple surgeries to treat his or her condition. But, sometimes, a patient must be readmitted for a reason that could have been avoided, such as complications from taking medication improperly because no one explained how to take it.<sup>5</sup> Beginning in 2013, hospitals that have high rates of readmissions for certain health conditions will see their Medicare payment rates reduced. Hospitals can decrease the number of avoidable readmissions by providing better care when the patient is in the hospital. Hospitals can also reduce readmissions by improving communication with patients (and their caregivers) and other health care providers who care for the patient. That way, patients know how to care for themselves when they leave the hospital and their doctors know, for example, what tests were performed while the patient was in the hospital and what medications the patient was prescribed.

The Affordable Care Act also builds on existing efforts to improve care and save money when patients are in the hospital. Since October 2008, Medicare has imposed a financial penalty on hospitals each time a patient experiences certain hospital-acquired conditions (HAC). A hospital-acquired condition is an injury or illness that a patient develops while in a hospital that could have been avoided if the hospital provided safe, high-quality care, such as an injury from falling, bedsores, or an object being left in a patient during surgery. In some cases, Medicare doesn't pay for the extra care that the patient would need to treat the hospital acquired condition.

The Affordable Care Act takes this a step further. Starting in 2014, each hospital's record for hospital-acquired conditions will be posted publicly at [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov). Additionally, if a hospital has a high rate of certain hospital-acquired conditions, its total Medicare payment will be reduced by 1 percent.

### ■ **Encouraging Coordination between Health Care Providers**

Under Medicare's current fee-for-service payment system, health care providers are paid for each individual service they provide to a patient. This means that the more services they provide, the more money they are paid. This incentive to provide more care is a major contributor to increasing health care costs. The Affordable Care Act begins the process of moving away from the fee-for-service payment system and toward a value-based system, where health care providers are paid based on the value of the care they provide.

All providers can lower costs and improve the quality of care, thereby improving the value of the care, by working together to coordinate patient care. One of the new payment mechanisms created by the Affordable Care Act allows doctors, hospitals, and other health care providers to join together to form an accountable care organization (ACO). Providers in an accountable care organization will take responsibility for the cost and quality of health care delivered. If the accountable care organization delivers high-quality care at lower costs, the providers in the accountable care organization can share in the savings they generate. By working together, health care providers can avoid duplicating tests and can monitor a patient's prescription drugs to make sure they are not taking medications that interact poorly, among other things. This new payment approach will create an estimated \$5 billion in savings for the Medicare program. Importantly, it will also improve the quality of the care that beneficiaries receive and lay the groundwork for more substantial savings and improvements in the future.

### ■ **Modernizing Medicare's Payment System**

The majority of the Affordable Care Act's savings within Medicare come from altering the way hospitals, nursing homes, and other health care facilities are paid. Traditionally, Medicare increases payments to hospitals and other health care facilities using a complicated formula each year. Each hospital gets this increase regardless of whether it is providing good quality, efficient care. The health reform law changes this.

The Affordable Care Act reduces these annual adjustments over the next 10 years. The purpose of this change is to encourage hospitals and other health care facilities to improve their productivity through increased efficiency. Each year, other industries increase their productivity by improving their efficiency so that they provide more for less, which lowers costs for consumers. The health reform law applies this same principle to the health care industry, saving the Medicare program \$205 billion over 10 years.

Some people have questioned whether hospitals will be able to continue to operate after these payment reductions take effect. But, the hospital industry agreed to these payment reductions, acknowledging that they will gain from the millions of newly insured people and that savings can be achieved through improved efficiencies, such as preventing duplication of tests by using electronic health records to monitor the care a patient has already received.<sup>6</sup> Also, hospitals will be able to avoid some of the payment reductions by providing quality care. Beginning in 2012, hospitals that meet certain performance levels will receive higher Medicare payments. (To learn more about what we mean when we talk about “efficient care,” see “What Is Efficient Health Care Delivery?” below.)

### What Is Efficient Health Care Delivery?

The efficient delivery of health care can be thought of as the delivery of the best possible care without wasting time and resources—essentially, a system in which the right patient gets the right care at the right time. There isn’t just one way to deliver efficient health care. Many different models or approaches exist and can be used together. Health care providers across the country are already experimenting with different ways to provide efficient care. For example, by reducing or eliminating the provision of duplicative health care services, doctors can spend more time with patients and costs can be lowered. One way to reduce duplicative care is by using electronic health records. If a patient’s doctors and other health care providers can access and share an electronic health record, they can see what other tests and treatments that the patient has already received and avoid repeating them. By coordinating care, health care providers can work together to ensure that the patient receives the appropriate amount of care, which will increase the value of each dollar spent on health care. Ensuring that a patient gets the right test the first time means that the patient and his or her insurance company won’t have to pay for unnecessary care. This will lower costs not only for the patient, but also for the entire health care system.

- **Leveling the Playing Field between Original Medicare and Medicare Advantage**

In recent years, overpayments to Medicare Advantage plans have been identified as a substantial source of waste within the Medicare system. These plans were established in the 1980s with the expectation that they would lower costs for Medicare by providing coverage more efficiently. Instead, Medicare Advantage plans have been paid an average of 14 percent more than it would have cost to treat the same beneficiary in original Medicare. In 2009, that was equal to about \$1,138 per beneficiary, for a total of \$11.4 billion in overpayments. As a result of this increased cost, Medicare Part B premiums are about \$3.00 more per month than they otherwise would be for all Medicare beneficiaries, not just those in these private plans. While these overpayments generated considerable profits for the private insurance companies, they do not benefit the Medicare trust fund. Instead they move up the insolvency of the trust fund by 18 months.

In 2011, under the Affordable Care Act, payment rates for Medicare Advantage plans will be frozen at 2010 levels. Preliminary information shows that the majority of Medicare beneficiaries will have access to multiple Medicare Advantage plans in 2011 and that premiums and cost sharing in these plans is stable. Additionally, estimates show that Medicare Advantage will experience a 5 percent increase in enrollment in 2011.<sup>7</sup>

Beginning in 2012, rates will be reduced over a three- to seven-year period so that costs are closer to those of original Medicare. High-quality plans will receive bonus payments of 5 to 10 percent. These changes will save the Medicare program \$145 billion.

Opponents of health reform claimed that these changes would result in beneficiaries in Medicare Advantage plans losing their coverage. In fact, Medicare beneficiaries will not lose coverage for Medicare's guaranteed benefits, which include hospital inpatient coverage and doctor's visits, among other things. Each private plan will have to make a business decision about how it wants to operate under the new payment system. Plans that are not able to provide health coverage efficiently may reduce coverage or withdraw from Medicare. But, high-quality, efficient plans will continue to offer coverage, and the new quality bonuses may make these plans more attractive.<sup>8</sup> Furthermore, Medicare beneficiaries always have the option of getting coverage through original Medicare if they no longer like their Medicare Advantage plan.



### ■ **Eliminating Waste, Fraud, and Abuse**

The Affordable Care Act takes significant steps to protect Medicare by cracking down on waste, fraud, and abuse. The law provides relevant agencies with an additional \$350 million over the next decade to hire more investigative personnel to aggressively monitor and prevent waste, fraud, and abuse in the system.

The health reform law will require Medicare providers to go through stricter screenings, like background checks and site visits, to ensure that fraudsters, such as a doctor who bills for services he or she never provided, never enter the program to begin with. Additionally, the Affordable Care Act imposes harsher fines and penalties on Medicare participants who submit false data on applications and claims. With stronger penalties, bad actors should be deterred from committing fraud and abusing the system in the first place.

The nonpartisan Congressional Budget Office (CBO) estimates that every \$1 invested to fight fraud results in \$1.75 in savings. The provisions in the law to fight waste, fraud, and abuse are expected to save the Medicare program about \$5 billion over the next 10 years.

## **Improving Medicare Benefits**

By making the Medicare system work better and rooting out waste in the system, there is more money available to improve benefits for people in Medicare.

### ■ **Closing the Doughnut Hole**

When the Medicare Part D prescription drug program was created, it included a gap in coverage known as the doughnut hole. When a beneficiary reaches the doughnut hole, he or she has to pay the full cost for medications. In 2010, the coverage gap begins once the beneficiary has paid \$2,830 for prescription drugs and ends once prescription drug costs reach \$6,440. This means a beneficiary must spend \$3,610 out of pocket before catastrophic coverage starts.

The Affordable Care Act closes that gap, saving beneficiaries money and improving access to needed medications. In 2010, any beneficiary falling into the coverage gap is receiving \$250 to help defray the cost of medications. Starting in 2011, anyone who falls into the coverage gap will receive a 50 percent discount on brand name drugs and a 7 percent discount on generic medications. Each year after that until 2020, the discount provided will increase, until the coverage gap is closed.



### ■ **Moderating Premiums**

Most Medicare beneficiaries won't see the growth in their Medicare Part B premiums that they otherwise would have seen if the Affordable Care Act had not passed. By 2018, Medicare Part B premiums are estimated to be \$200 less per year than they otherwise would have been. Medicare beneficiaries with higher incomes (\$85,000 per individual and \$170,000 per couple), though, will continue to pay higher premiums based on their income level for Medicare Part B and will also now pay higher premiums for Medicare Part D. This builds on a provision that was first included in the 2003 Medicare Modernization Act, which charged high-income beneficiaries Part B premiums based on their income.

### ■ **Improving Access to Preventive Services**

Currently, Medicare only covers a limited number of preventive health services, like mammograms and diabetes screenings. But, even then, beneficiaries may be liable for the deductible and co-insurance. If Medicare doesn't cover the service, like an annual physical exam, the beneficiary must pay the full cost of the service. Since this is can be unaffordable for Medicare beneficiaries, they may forgo these services on a regular basis.

The Affordable Care Act recognizes the importance of preventive health care, both in terms of how it can improve people's health and the savings it can create for the health care system. That's why, for the first time in the history of the Medicare program, beneficiaries will no longer have to pay out of their own pockets for preventive services like cancer screenings or mammograms. Medicare will also be able to add coverage in the future for new preventive services that are found to be effective.

The Act also gives beneficiaries the option to spend more time with their doctor at their annual physical to develop a personalized prevention plan together. These plans include information about the beneficiary's current health status and a schedule for preventive services that the beneficiary should get over the next five to 10 years.

## **Conclusion**

As the health care system advances and new, more expensive treatments become available, the Medicare program must also adjust to meet the changing needs of the covered population. It must ensure that it can continue to offer the coverage that millions of seniors and people with disabilities have come to rely on. The savings in health reform come from improving the way Medicare pays providers, encouraging them to offer higher quality, more efficient services, which not only saves money, but improves the care for Medicare beneficiaries across the country.

## Endnotes

<sup>1</sup> Centers for Medicare and Medicaid Services, *Affordable Care Act Update: Implementing Medicare Cost Savings-* (Washington: CMS, August 2010), available online at <http://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf>.

<sup>2</sup> Kaiser Family Foundation, *Medicare Spending and Financing Fact Sheet* (Washington: Kaiser Family Foundation, August 2010), available online at <http://www.kff.org/medicare/upload/7305-05.pdf>.

<sup>3</sup> Jennifer O'Sullivan, *Medicare: History of Part A Trust Fund Insolvency Projections* (Washington, DC: Congressional Research Service, March 28, 2008), available online at <http://aging.senate.gov/crs/medicare14.pdf>.

<sup>4</sup> Kaiser Family Foundation, *Medicare Savings in Perspective: A Comparison of 2009 Health Reform Legislation and Other Laws in the Last 15 Years* (Washington: Kaiser Family Foundation, December 2009), available online at <http://www.kff.org/healthreform/upload/7983-02.pdf>.

<sup>5</sup> The Medicare Payment Advisory Commission (MedPAC) in its 2007 report to Congress estimated that about 18 percent of patients were readmitted to the hospital within 30 days of being discharged and of that about 13 percent were potentially avoidable. MedPAC estimated the cost to Medicare for potentially avoidable readmissions within 30 days of discharge was \$12 billion. Available online at [http://www.medpac.gov/chapters/Jun07\\_Ch05.pdf](http://www.medpac.gov/chapters/Jun07_Ch05.pdf).

<sup>6</sup> Ceci Connolly and Michael Shear, "Hospitals Reach Deal with Administration," *The Washington Post*, July 7, 2009, available online at <http://www.washingtonpost.com/wp-dyn/content/article/2009/07/06/AR2009070604053.html>.

<sup>7</sup> Centers for Medicare and Medicaid Services, *Medicare Advantage Premiums Fall, Enrollment Rises, Benefits Similar Compared to 2010* (Washington: CMS, September 21, 2010), available online at <http://www.cms.gov/apps/media/press/release.asp?Counter=3839&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cbOrder=date>.

<sup>8</sup> Humana Inc. President and CEO Michael B. McCallister "told industry analysts during a conference call to discuss quarterly earnings that Medicare Advantage remains a tremendous opportunity and acknowledged that he's been surprised that more competitors haven't ventured into the market." "On the Call: Humana CEO Michael McCallister," *Associated Press/Bloomberg BusinessWeek*, August 2, 2010, available online at <http://www.businessweek.com/ap/financialnews/D9HBFU5G0.htm>.



1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005

Phone: 202-628-3030 ■ E-mail: [info@familiesusa.org](mailto:info@familiesusa.org)

[www.familiesusa.org](http://www.familiesusa.org)