Changes to Medicare under the Affordable Care Act

By Jack Davidson and Jonathan Levin

The Affordable Care Act (ACA) made substantial changes to Medicare. Supporters of the ACA hoped the 2010 law would improve the efficiency of Medicare by reforming payments and health care delivery while also lowering costs.

Some of the notable reforms included adjustments to slow the growth of Medicare prices, attempts to reduce expenditures in Medicare Advantage, and a range of programs that reward or penalize health care providers based on how they perform relative to quality or cost targets. Early evidence suggests some success in slowing cost growth, but the potential long-term impact of far-reaching payment reforms is still hard to assess.

These policy changes have been overshadowed by the controversy over the ACA's reforms to the individual health care market and the expansion of Medicaid. But with the new Congress poised to revisit and likely repeal parts of the Affordable Care Act, Medicare may come under the microscope again. This Policy Brief reviews the ACA reforms to Medicare and how they have played out over the last seven years.

Traditional Medicare (Parts A & B)

The ACA mandated several broad sets of reforms to the traditional fee-for-service (FFS) Medicare program. These reforms included an attempt to slow cost growth by changing the formula for Medicare payments, as well as programs and demonstrations that attempt to shift the structure of Medicare payments and the incentives of health care providers.

Medicare reimburses providers for services based on administrative payment schedules. The Centers for Medicare and Medicaid Services (CMS) update these schedules each year to reflect changes in medical costs. The update reflects changes in the costs of providing different services. The ACA mandated that calculations of these cost changes should incorporate productivity growth that enables health care providers to use their resources more efficiently.

Figure 1 illustrates the impact of the ACA productivity adjustment using CMS Inpatient Hospital data (2000-2017). So far, the adjustments have been relatively small on an annual basis, on the order of 0.5 to 1.0 percent (the 2017 number is slated at 0.3 percent). However, the adjustments cumulate over time, so that as of 2017 payments are 3.45 percent lower than they would have been with the old unadjusted index.

Over time, the policy will cut meaningfully into prices. A hospital that receives $2,500 for performing a cardiac catheterization and expects this to rise to $3,000 over a decade might see that growth cut by $150.

An open and significant question is whether the productivity adjustment will be sustainable. In the short run, Medicare has some flexibility to reduce payment growth. Over a longer period, payments need to be high enough to induce hospitals and physicians to accept Medicare insurance. Ultimately, the sustainability of the ACA adjustment will depend on whether health care productivity gains keep up with those of the economy at large so that providers remain willing to participate.

About the Authors

Jack Davidson is a sophomore at Dartmouth College, majoring in economics. He was a research assistant at SIEPR during the summer of 2016.

Jonathan Levin is the Philip H. Knight Professor and Dean of the Stanford Graduate School of Business and a senior fellow at SIEPR.
Another set of ACA reforms, with less direct budget consequences but potentially far-reaching effects, address the structure of Medicare payments. Experts have long pointed to two structural problems with fee-for-service payments. First, they provide no direct reward for quality of care. Second, they provide no incentive for physicians or hospitals to forgo unnecessary tests or procedures, or expensive treatments with relatively low health benefits.

Two ACA programs aim to reward hospitals for quality of care: the Hospital Readmissions Reduction Program (HRRP) and Hospital Value Based Purchasing (HVBP). Both adjust hospital payments based on selected quality metrics, imposing penalties on hospitals that underperform and in the case of the HVBP awarding bonuses to high-quality providers.

The HRRP seeks to reduce Medicare hospital readmissions and these have fallen since 2012, just prior to the implementation of HRRP payments. Establishing causality is a delicate issue, although looking across hospitals there is some evidence that access to HRRP payments is associated with reduced readmissions. In the case of the HVBP, a Government Accountability Office (GAO) review in 2015 found little impact on quality or payments. However, the program’s quality metrics and incentive structure have been changing and the GAO observed that future effects could be more substantial.

To address over-utilization of services, the ACA also initiated the Medicare Shared Savings Program (MSSP), which rewards providers for keeping patient costs below a target level. Because patients often receive care from a combination of doctors, hospitals, and other facilities, a central component of the MSSP is a reliance on Accountable Care Organizations (ACOs).

ACOs are groups of providers that can coordinate health care for groups of beneficiaries and contract with the government for shared savings. An ACO might include one or more hospitals, additional outpatient clinics, and dozens or hundreds of physicians. For instance, the POM ACO associated with the University of Michigan Medical School’s Faculty Group Practice has more than 5,000 providers and 12 physician groups and covers roughly 120,000 patients in 22 Michigan counties.

In large part due to their inclusion in the Affordable Care Act, ACOs have seen a meteoric rise since their inception roughly 10 years ago. As of 2016, the government had signed contracts with 477 ACOs covering 8.9 million Medicare beneficiaries, including 434 ACOs in the MSSP. The total number of ACOs in the United States has grown from 64 in 2011 to 838 in 2016. Although the jury is still
out on how the spread of ACOs will affect the quality and cost of health care, it is possible that organizational changes in health care delivery could be among the most meaningful impacts of the ACA.

In addition to reforming Medicare payments, the ACA also attempted to establish two new institutions within the Medicare program. One of these, the Independent Payment Advisory Board (IPAB), was designed as a backstop to limit Medicare cost growth. It was charged with implementing cuts in the Medicare program in the event of certain cost triggers, which so far have not been realized. The IPAB was extremely controversial from the start. To date, no members have been nominated, and the IPAB seems unlikely to see the light of day anytime soon.

The other institution—the Center for Medicare and Medicaid Innovation (CMI)—has been more successful. The CMI primarily houses demonstration programs testing innovations in Medicare and Medicaid payments. While demonstration programs existed prior to the ACA, their number has grown. Currently, there are 27 ongoing demonstrations relating solely to the Medicare program, many of which are focused on alternative payment models such as quality-based payments or payments for “episodes of care” rather than individual services.

As of January 2016, more than 20 percent of fee-for-service payments went through an alternative payment model, and Sylvia Burwell, the Obama administration’s secretary of Health and Human Services, set a goal of increasing that level to 50 percent by 2018. Whether the new administration will try to reach this goal is an open question.

Medicare Advantage (Part C)

The ACA also mandated significant changes to the Medicare Advantage program, which allows Medicare beneficiaries to enroll in private insurance plans. In the years preceding the ACA, Medicare Advantage payments to insurers became more generous and enrollment expanded steadily. As of 2009, Medicare Advantage spending per beneficiary had ballooned to 113 percent of the per capita cost of traditional Medicare, contrary to the program’s goal of reducing taxpayer costs. The ACA targeted the level of Medicare Advantage payments to insurance plans and also tied them to measures of plan quality.

Figure 2 shows the reduction in Medicare Advantage spending relative to traditional fee-for-service Medicare since the implementation of the ACA. The three lines reflect the complicated nature of price setting in the Medicare Advantage program. The blue line shows benchmark payments set by the government. The red line shows

![Figure 2. Medicare Advantage Bids, Benchmarks, and Payments (percent of FFS spending)](chart)

Source: Medicare Payment Advisory Commission (2016), Health Care Spending and the Medicare Program: Data Book
bids made by Medicare Advantage insurers. The grey line shows the ultimate government payments per Medicare Advantage enrollee relative to per-capita fee-for-service spending. The payment reforms have triggered roughly a 10 percent decline in Medicare Advantage spending relative to fee-for-service, saving around $16 billion dollars in 2016.

The ACA reductions involved several specific changes. One was to limit the growth in benchmark rates that set regional baselines for Medicare Advantage reimbursement. Here the goal was to bring those payments back in line with regional fee-for-service spending. This was coupled with an adjustment to the risk-coding used to ensure that plans with relatively sick enrollees receive larger payments.

Medicare uses a predictive formula to “score” each beneficiary on his/her expected medical costs, using the individual’s age and chronic illnesses. Under this system, private insurers have a strong financial incentive to make sure chronic conditions are recorded, and analysts have noted that due to thorough (some would say aggressive) coding, risk scores in Medicare Advantage rise more rapidly than risk scores in traditional Medicare.

To counteract this, the Deficit Reduction Act of 2005 and later the ACA instituted a “coding adjustment” that scales down Medicare Advantage risk scores. As of 2016, this adjustment reduces the program’s plan payments by 5.41 percent.

The ACA also brought financial incentives into Medicare Advantage’s five-star quality system. The Centers for Medicare and Medicaid Services initiated the rating system for Medicare Advantage plans in 2008 in order to measure plan quality and performance. The ACA tied plan payments to these ratings, creating a direct financial reward to plans with higher quality ratings.

The CMS has argued these payments have led insurers to focus on achieving higher ratings, driving increases in quality of care. Figure 3 uses Kaiser Family Foundation data on Medicare Advantage enrollment to show the resulting increase in plan quality. Between 2013 and 2016, plan enrollment shifted significantly from three-star plans into four-star plans.

A final aspect of the ACA reforms to Medicare Advantage was to directly target the operating profits of insurers. Specifically, the ACA mandated that the Medical Loss Ratio (MLR) of Medicare Advantage plans must be at least 85 percent. The MLR captures the dollar amount of health claims paid relative to plan revenue, so an 85 percent maximum MLR.

Figure 3. Medicare Advantage Enrollment in Plans by Star Rating (percentage of total)

Source: Kaiser Family Foundation, Medicare Advantage 2016 Spotlight

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means that a plan can use no more than 15 percent of its revenue to cover administrative costs, insurance company profits, and non-health care related items.

In principle, this relatively blunt form of regulation could have significant effects on insurer behavior. However, the GAO has found that a majority of insurers already met the MLR requirements at the time the ACA was passed in 2010 and more than three-quarters of plans met the requirements in 2011. So due to a relatively easy-to-meet standard and exceptions in the law for certain types of plans, the MLR restriction does not yet appear to have had much impact.

Implications of the ACA Reforms to Medicare

Health care spending growth has slowed in recent years and part of the slowdown, which began in 2007, has been a lower rate of per capita Medicare cost growth. Proponents of the ACA have been quick to take credit but, as we describe, the evidence is more ambiguous.

Figure 4 uses National Health Expenditure Accounts data on Medicare spending and enrollment to show the real change in Medicare per capita growth. There is a sharp spike in 2006 with the introduction of Medicare Part D prescription drug coverage. Starting the following year, cost growth has been muted compared with earlier periods. The magnitude of this cost slowdown is significant. Although the most recent data show an uptick, growth since 2007 has been slower than any time since the Balanced Budget Act of 1997 made significant cuts to Medicare.

Kaiser Family Foundation analysts looked at how much of the slowdown in Medicare spending could be attributed directly to the ACA. They compared actual Medicare spending in 2014 with the Congressional Budget Office’s pre-ACA projection of spending in 2014. They found that the most direct ACA cost reductions—the productivity adjustment to Medicare prices and the payment adjustments in Medicare Advantage—could explain around a third of the Medicare “savings” in 2014. Their analysis finds additional savings from subsequent policy changes, but leaves around 50 percent of the Medicare savings unexplained.

This suggests that a significant amount of the slowdown in Medicare cost growth relates to the broader slowdown in health care costs, for which multiple explanations exist including the Great Recession, greater efficiencies in health care delivery, slower innovation in health care technology, and reduced spending on imaging and prescription drugs.

An interesting question is whether the ACA push toward rewarding providers for meeting quality or cost
targets may be indirectly responsible for slowing Medicare and overall health care spending growth. An optimistic story would be that ACA changes in payment structure, which also are entering the commercial sector, have triggered organizational changes and improved efficiency. As noted above, it is still early to assess this hypothesis. With the new Congress likely considering further changes in Medicare, it is unclear if we will get an answer on the long-run impact of the payment reforms.

References

For a full list of references, please see Davidson, J. & Levin, J. (2016). Changes to Medicare under the Affordable Care Act, prepared for the Alfred P. Sloan Foundation.


