We'll Show You Cost Containment

How Federal Health Reform will Help Reel in Health Care Costs

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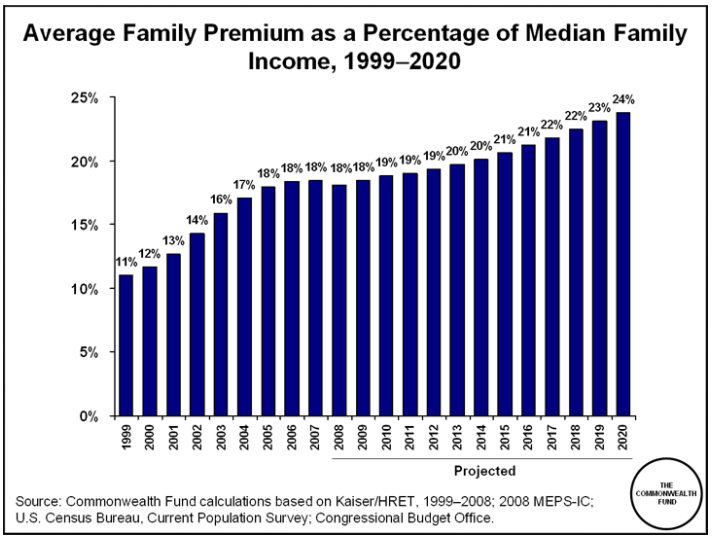
Summary

No matter where one stands on the spectrum of opinion about health reform, just about everyone can agree that health care costs are out of control. In fact, the US spends more on health care than any other industrialized country, and expenditures keep growing even though so many Americans don't reap the benefits. Over 16% of Americans (14% of Utahns) do not have any kind of health insurance.[i] And, the number of people who have private health insurance is dropping.[ii] For those that do have insurance, premiums are projected to hit 24% of median family income by 2020!



Source: K. Davis, *Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums,* (New York: The Commonwealth Fund, August 2009). www.commonwealthfund.org/.../**2009**/.../PPT_Schoen_aging_comm_testimony_figures.ppt

How will the ACA control health care costs?

Federal Health reform (the Affordable Care Act or ACA) employs a variety of measures to contain health care costs. As we show in this paper, the ACA has more robust cost containment than Utah's health reforms. This is ironic in view of state leaders' decision to begin their 10-year reform process with cost containment strategies and then use the savings later, around

Bob Cole works for Progressive Remodelers Inc., a local small business that provides home remodeling services. Progressive offers health insurance to its employees and covers 100% of the premium. This means their bids can be higher than companies that don't provide insurance, making it difficult to compete. Still, they enjoy the positive results—they've been able to retain quality employees. However, with the recent economic downturn, they've had to look seriously at whether they can continue to provide coverage. In the last 7 years Progressive's premiums have risen over 300%! When Bob learned about the ACA tax credits, he was relieved.

"We have decided to continue to offer insurance this year largely in part to the small business premium tax credit we will receive thanks to the Affordable Care Act."

year 10, to cover the uninsured. For many years states have served as laboratories of cost containment strategies,[iii] and Utah is well poised to add to the toolbox. The ACA is designed to build on what works across the states and to foster innovations to limit cost growth and improve quality of care in government programs.

The ACA has a 3-prong strategy for slowing the rate of cost growth and reining in health care costs for employers and consumers:

1. **Reform payment and delivery systems** to minimize unnecessary costs to the system and re-align incentives to provide better care at less cost.
2. **Improve quality and coordinate care** for people with chronic conditions via medical homes and care management.
3. Use **insurance reforms** to limit costs of insurance for individuals and businesses and manage risk.

By 2019 the ACA will have reduced health care spending by an estimated $590 billion, slowing the annual growth rate in national health expenditures from 6.3 percent to 5.7 percent.[iv] This translates to real savings for people who have health insurance—insurance companies will be required to justify and get approval for premium hikes and they will have to spend at least 80% of premium dollars for small groups (85% for large groups) on actual medical care, rather than on administration or profits. Insurance premiums are projected to decrease by nearly $2,000 per family as a result of the ACA.[v] It means help for people who are currently insured but struggling to pay— affordability standards will guide eligibility for premium subsidies to help low- and middle-income families buy insurance on the private market. Health plans will have to meet a minimum level of quality, ensuring better value for all payers. The affordability standards and premium subsidies will help many of the uninsured buy health insurance and public programs will remain the most cost-effective coverage option for those who cannot afford insurance at all.

When people have health insurance they have access to health care—and that costs less. People with health insurance (private or public) use health care resources more efficiently and appropriately, and they have better health outcomes than those who don't. People with inadequate health insurance delay care or forgo it completely—costing the system more when they show up in emergency departments with complicated and advanced conditions needing treatment.

How the Affordable Care Act (ACA) will Lower Costs for Consumers— and Why this Matters for Overall Cost Containment

The ACA places a cap on what insurance companies can require individuals to pay in out-of-pocket expenses, such as co-pays and deductibles. This will ensure that Americans are not forced to file bankruptcy due to high health care costs. It also eliminates lifetime limits on how much insurance companies cover if you get sick and regulates plans' use of annual coverage limits until 2014, when they are prohibited.

Effective 2014, premium assistance tax credits will limit the amount an individual must spend on their premium for the essential benefits package from 2% of income at 100% of the Federal Poverty Level (FPL) to 9.5% of income at 300-400% of the FPL. The amount of the credit is tied to the premium of the second-lowest cost (silver) plan in each area.

The ACA also provides credits to reduce the amount of cost-sharing for lower-income individuals. Their annual out-of-pocket limits would be a fraction of the standard amount: one-third for those with incomes below 200% of the FPL, half for those with incomes from 200-300% of the FPL, and two-thirds for those with incomes from 300-400% of the FPL. In addition, state-based Exchanges will help eligible individuals and small employers compare and purchase health care coverage at competitive prices online.

Cost Control Measures in Federal Health Reform (Examples)

A selection of cost-containment measures in the Affordable Care Act is shown in the table below in chronological order. Several (like "health home" demonstrations) are offered as options and tools to states.

Implementation date	Provisions	Description	Cost control category
Reports to Congress January 1 2011	Value-Based Purchasing Programs	Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.	Payment/Delivery System Reform
January 1 2011	Medicare Premiums for High-Income Beneficiaries	Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.	Payment/Delivery Reform
January 1 2011	Minimum Medical Loss Ratio for Insurers (MLR)	Requires plans to report the proportion of premiums spent on clinical services or quality improvements; provide rebates to consumers if the share of premium spent on clinical services and quality is less than 85% for plans in large group market and 80% for plans in the individual and small group markets.	Insurance Reform
January 1 2011 to December 31 2015	Medicare Payments for Primary Care	Provides a 10% bonus payment for primary care services; also, provides 10% Medicare bonus payment to general surgeons practicing in health professional shortage areas.(see where Utah falls short: http://hpsafind.hrsa.gov/).	Payment/Delivery Reform
Established Jan 1 2011	Center for Medicare and Medicaid Innovation	Creates the Center for Medicare and Medicaid Innovation to test new payment and delivery system models that reduce costs while maintaining or improving quality.	Payment/Delivery Reform
January 1 2011	Medicaid Health Homes	Creates a new Medicaid state option to permit certain Medicaid enrollees to designate a provider as a health home and provides states taking up the option with 90% federal matching payments for two years for health-home related services.	Improve quality & coordinate care
Grants awarded March 23 2011; Implement Jan 1 2014	Funding for Health Insurance Exchanges	Provides grants to states to begin planning for the establishment of American Health Benefit Exchanges and Small Business Health Options Program Exchanges, which facilitate the purchase of insurance and mangement of risk for individuals and small groups.	Insurance Reform
Funding available October 1 2011; first recommendation due January 15 2014	Medicare Independent Payment Advisory Board	Establishes an Independent Advisory Board, comprised of 15 members, to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds targeted growth rates.	Payment/Delivery Reform

Implementation date	Provisions	Description	Cost control category
January 1 2012	Accountable Care Organizations (ACOs) in Medicare	Allows providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountablefor the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care.	Payment/Delivery Reform
Begins calendar, fiscal, or rate year of 2012, as appropriate	Medicare Provider Payment Changes	Adds a productivity adjustment to the market basket update for certain providers, resulting in lower rates than otherwise would have been paid.	Payment/Delivery Reform
January 1 2012	Fraud and Abuse Prevention	Establishes procedures for screening, oversight, and reporting for providers and suppliers that participate in Medicare, Medicaid, and CHIP; requires additional entities to register under Medicare.	Payment/Delivery Reform
January 1 2012 through December 31 2016	Medicaid Payment Demonstration Projects	Creates new demonstration projects in Medicaid for up to eight states to pay bundled payments for episodes of care that include hospitalization and to allow pediatric medical providers organized as ACOs to share cost-savings.	Payment/Delivery Reform
March 23 2012	Data Collection to Reduce Health Care Disparities	Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, + disability status, and for underserved rural and frontier populations.	Payment/Delivery Reform
October 1 2012	Medicare Value-Based Purchasing	Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting beyond 2010; requires plans to be developed to implement these programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.	Payment/Delivery Reform
October 1 2012	Reduced Medicare Payments for Hospital Readmissions	Reduces Medicare payments that would otherwise be made to hospitals to account for excess (preventable) hospital readmissions.	Payment/Delivery Reform
January 1 2013	Medicare Bundled Payment Pilot Program	Establishes a national Medicare pilot program to develop and evaluate making bundled payments for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.	Payment/Delivery Reform
January 1 2013 through December 31 2014	Medicare Payments for Primary Care	Increases Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding).	Payment/Delivery Reform

Please refer comments and questions to Shelly Braun, Ph.D., Reform Initiatives Director
(801) 433-2299 shelly@healthpolicyproject.org

Implementation date	Provisions	Description	Cost control category
January 1 2013	Medicare Tax Increase	Increase the Medicaid Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and imposes a 3.8% assessment on unearned income for higher-income taxpayers.	Payment/Delivery Reform
Fiscal Year 2013	Extension of CHIP	Extends authorization and funding for the Children's Health Insurance Program (CHIP) through 2015 (current authorization is through 2013).	Payment/Delivery Reform
January 1 2014	Health Insurance Exchanges	Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage and share risk.	Insurance Reform
January 1 2014	Guaranteed Availability of Insurance	Requires guaranteed issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.	Insurance Reform
January 1 2014	No Annual Limits of Coverage	Prohibits annual limits on the dollar value of coverage.	Insurance Reform
January 1 2014	Essential Health Benefits	Creates an essential health benefits package that provides a comprehensive set of services, limiting annual cost-sharing to the Health Savings Account limits ($5,950/individual and $11,900/family in 2010).	Insurance Reform
January 1 2014	Multi-State Health Plans	Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.	Insurance Reform
January 1 2014 through December 31, 2016	Temporary Reinsurance Program for Health Plans	Creates a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.	Insurance Reform
1st Recommendations due January 15 2014 (funding available October 1 2011)	Medicare Independent Payment Advisory Board Report	Establishes an Independent Advisory Board, comprised of 15 members, to develop recommendations to reduce per capita rate of growth in Medicare spending if spending exceeds a target growth rate.	Payment/Delivery Reform

Implementation date	Provisions	Description	Cost control category
January 1 2018	Tax on High-Cost Insurance	Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers [CPI-U] for years beginning in 2020). coverage, excluding dental and vision coverage.	Insurance Reform
January 2018	Medicare Independent Payment Advisory Board Recommendation	The target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for consideration.	Payment/Delivery Reform

Source: http://healthreform.kff.org/timeline.aspx

Conclusion

The Congressional Budget Office (CBO) estimates that the Patient Protection + Affordable Care Act (ACA) will reduce the deficit by $124 billion over 10 years. The costs of the ACA are financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance that the CBO estimates will save an additional $32 billion over 10 years.

Real reform of our health care system will not happen overnight. The ACA cost containment measures will be rolled out over time and stay responsive to the changing health care and economic environments. Many build on and maximize proven strategies across the states and provide mechanisms like the new Centers for Innovation to develop and fine tune new strategies to deepen savings over time and sustain all payers' investment in quality health care and coverage.

This report was prepared with assistance from Derek Chang, a pre-med student at the University of Utah.

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[i] US Census Bureau. (2010, September 16). Income, Poverty and Health Insurance Coverage in the United States: 2009. Available at http://www.census.gov/newsroom/releases/archives/income_wealth/cb10-144.html.
[ii] Ibid.
[iii] National Conference of State Legislatures (2011). Health Cost Containment & Efficiencies: Options for State Legislatures. Powerpoint Summary presented to Utah Health System Reform Task Force. http://le.utah.gov/asp/interim/Commit.asp?Year=2011&Com=TSKHSR.
[iv] Cutler, D.M., Davis, K. & Stremikis, K. (2010). The Impact of Health Reform on Health System Spending. Commonwealth Fund pub. 1405, vol. 8. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/May/1405_Cutler_impact_hlt_reform_on_hlt_sys_spending_ib_v4.pdf.
[v] Ibid.

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