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Janet Weiner

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Did the Affordable Care Act Contain Costs?

Abstract

While the Affordable Care Act (ACA) primarily focused on expanding coverage to many of the [46 million](#) uninsured Americans at the time, it included various provisions that sought to slow the growth of health care spending. In an [LDI Issue Brief](#) two years ago, we looked at how the ACA provisions affected costs through 2015. We found little evidence that they had produced the changes necessary to “bend the cost curve,” although the double-digit growth rates of the 2000s had not returned. However, it is possible that the ACA’s changes have had more cumulative effects. This brief updates our earlier piece, and assesses the effects of the ACA on costs since its passage 10 years ago.

Keywords

aca, affordable care act, obamacare, health insurance, insurance marketplace, health care

Disciplines

Economic Policy | Health Economics | Health Policy | Health Services Administration | Health Services Research | Policy Design, Analysis, and Evaluation

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DID THE AFFORDABLE CARE ACT CONTAIN COSTS?

A Ten-Year Look

Janet Weiner, PhD, MPH

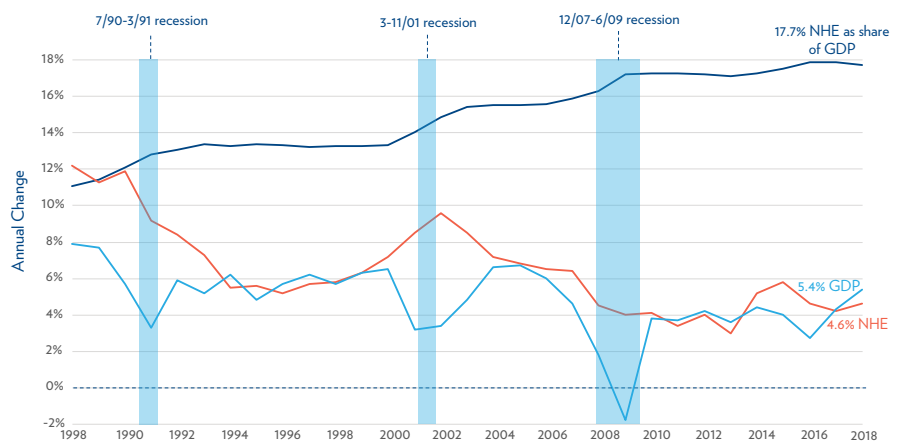
The Affordable Care Act was designed to curb the growth of health care costs as it broadly expanded coverage. Through provider payment reductions, alternative payment models, and a commission to enforce growth targets, the ACA sought to rein in Medicare spending. Through a tax on high-cost employer plans and competition in individual marketplaces, it sought to influence spending in the private market as well. But a number of provisions were never implemented, limiting the ACA's impact on costs. While statutory reductions in Medicare provider rates have slowed cost growth in Medicare, they are not likely to be sustainable in the long term. Changing the trajectory of cost growth remains a challenge for future reform efforts.

While the Affordable Care Act (ACA) primarily focused on expanding coverage to many of the [46 million](#) uninsured Americans at the time, it included various provisions that sought to slow the growth of health care spending.¹ In an [LDI Issue Brief](#) two years ago, we looked at how the ACA provisions affected costs through 2015.² We found little evidence that they had produced the changes necessary to “bend the cost curve,” although the double-digit growth rates of the 2000s had not returned. However, it is possible that the ACA's changes have had more cumulative effects. This brief updates our earlier piece, and assesses the effects of the ACA on costs since its passage 10 years ago.

NATIONAL HEALTH CARE SPENDING

The growth of National Health Expenditures (NHE) reflects both macroeconomic trends and microeconomic factors. As shown in Figure 1, health care spending has grown steadily over 30 years, although it tends to slow in periods of recession.³

Figure 1. Growth in national health expenditures (NHE), gross domestic product (GDP), and NHE as share of GDP, 1988-2018



Adapted from Anne B. Martin et al., *National Health Spending: Faster Growth In 2015 as Coverage Expands and Utilization Increases*. (*Health Affairs*, January 2017).

Cost growth had slowed immediately prior to the ACA, which complicates any analysis to pinpoint the law’s specific effects. Not surprisingly, in 2014-2015, growth accelerated as millions of people gained access to health insurance, likely reflecting pent-up demand for care. Since then, as coverage stabilized, growth slowed substantially from 2015-2017, and accelerated slightly in 2018.

Any analysis of the effects of the ACA on costs is complicated by the factors that drive cost growth across time, including demographics, price, utilization, and technology. A recent [study](#) modeled the contribution of these factors to cost growth over time, and can help frame our understanding of the ACA’s possible effects.⁴ For example, while population growth and the age/sex mix of the population have an effect, their contribution does not change in the short-term; instead, short-term fluctuations are more readily explained by use and price of health care services. In Figure 2, we can see the effects of the ACA as large-scale coverage expansions began in 2014, as reflected in an increasing contribution of use and intensity of services from 2014-2016. We also see that medical prices explained more of the cost growth in 2017 and 2018, when coverage gains under the ACA stalled.

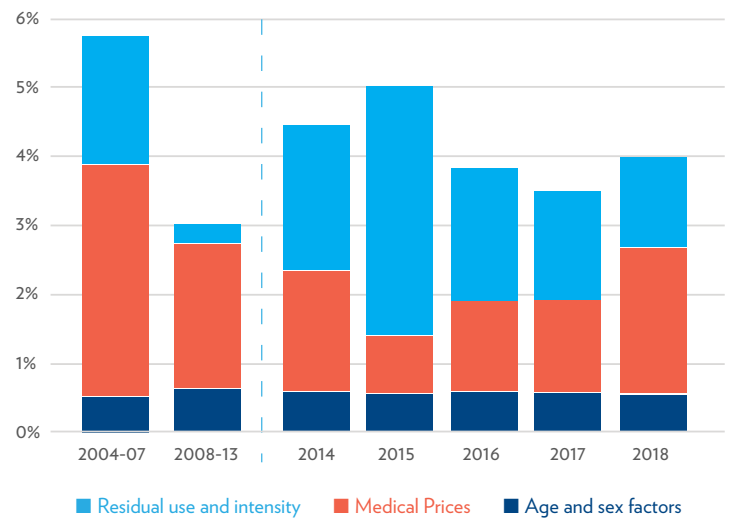
ACA’S EFFECT ON COST GROWTH

Here we review the cost containment provisions of the ACA and their possible effects. The ACA included provisions to rein in Medicare costs through mechanisms that could affect the unit price or utilization of services. Some provisions produced savings statutorily by reducing provider payment updates or adjusting Medicare Advantage (MA) payments to private plans. There is no question that these provisions reduced cost growth, although significant questions remain about their sustainability and their ability to “bend the cost curve” in the long term.

Medicare provider payment updates. The ACA reduced annual payment updates to most providers (other than physicians) by adjusting for economy-wide productivity gains. CMS estimated that the provider payment reductions produced federal savings of [\\$85 billion](#) between 2011-2016, savings that will continue to compound as long as the provisions remain in effect.⁵ However, historically, the health sector has been unable to improve productivity to the same extent as other industries. While this provision is generating year-to-year savings, by most accounts, it is unsustainable; if left unchecked, it will produce growing differentials with private rates, threatening beneficiary access and provider bottom lines. An [economic simulation](#) suggests that, by 2040, about 40% of hospitals, two-thirds of skilled nursing facilities, and 80% of home health agencies would have negative total facility margins.⁶

Medicare payment rates also have implications for Medicaid spending, where many services have “[upper pay limits](#)” (UPLs) that cannot exceed Medicare payment rates.⁷ As the differential between Medicare rates and private rates grows, it will force a similar differential for Medicaid, as

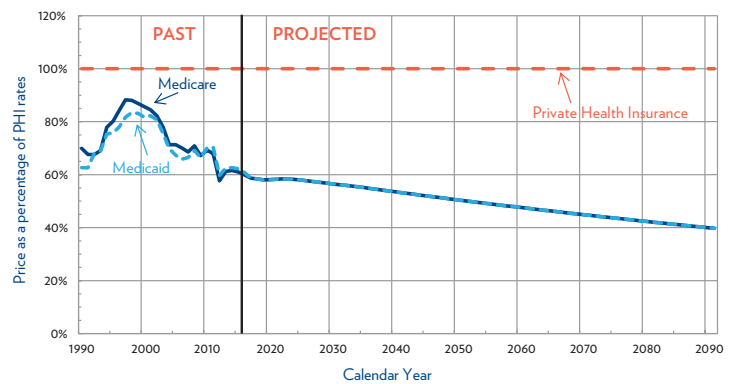
Figure 2. Factors accounting for growth in per capita national health expenditures (NHE), selected calendar years 2004-18



Notes: Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted NHE price deflator. “Residual use and intensity” is calculated by removing the effects of population, age and sex factors, and price growth from the nominal expenditure level.

Health Affairs, Health Spending Projections Through 2027. (February 2019).

Figure 3. Illustrative comparison of relative Medicare, Medicaid, and private health insurance prices for inpatient hospital services under current law



CMS Office of the Actuary, Projected Medicare Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers. (April 2019).

illustrated in Figure 3. In the long run, CMS estimates that Medicare and Medicaid provider rates could drop to 39% of private rates, a scenario that would raise serious access and quality issues for beneficiaries.⁶

Thus, many analysts predict that statutory reductions in annual payment updates to hospitals, other facilities, and home health care agencies will be phased out or repealed.

Medicare Advantage rates. Another provision achieved Medicare savings by cutting its capitated Medicare Advantage (MA) rates to private plans over six years. Reductions to MA plans corrected longstanding overpayments, estimated at [14%](#) higher than equivalent beneficiaries in the fee-for-service program.⁸ Despite concerns that these cuts would drive plans or enrollees away from MA, its share of the Medicare population grew from 19% in 2007 to 34% in 2017. Because of the ACA's changes to MA's benchmark and bidding system, by 2017, enrollees in MA plans cost, on average, the [equivalent](#) of fee-for-service enrollees, without noticeable reductions in beneficiary access or quality of care.⁹ While CMS estimated that these reductions in MA rates saved [\\$68 billion](#) through 2016, it is not likely that MA payments rates can continue to be cut to achieve future savings or affect the rate of growth.⁵

The Independent Payment Advisory Board. The ACA also included a safety valve if Medicare per capita spending did not meet certain targets. Exceeding these targets would trigger the institution of an [Independent Payment Advisory Board](#) (IPAB), a commission that would propose reimbursement cuts if the five-year growth average in Medicare per capita spending exceeded growth targets.¹⁰ IPAB was universally unpopular, never formed, and formally [repealed](#) in 2018.¹¹

Alternative payment models. The ACA also authorized market-based reforms targeted to service utilization, to encourage greater efficiency and higher quality of care for Medicare beneficiaries. Most of these reforms have been small-scale, often voluntary programs that were not intended to produce large savings. These reforms shift risk to providers, with payments tied to improved quality or reduced net cost. Evidence for many specific models remains limited or mixed. So far, payment reforms such as [bundled payments](#) and [Accountable Care Organizations](#) (ACOs) have yielded very modest spending reductions for certain procedures and types of patients.^{12,13}

Bundled payments put providers at financial risk for the total cost of care for an episode of care, such as hip or knee replacements. Providers are penalized for going over a benchmark price, and share in the savings for coming under the target. Bundled payments do appear to modestly reduce per-episode costs for many surgical procedures, saving about [1.6%](#) for hip and knee replacements, but [no per-episode or overall savings for medical conditions](#) such as heart attacks or pneumonia.^{14,15}

The most common ACO program, the [Medicare Shared Savings Program](#) (MSSP) has more than 500 participating ACOs that cover over 11 million lives.¹⁶ ACOs earn shared savings if they come in under a benchmark annual growth rate. In 2010, the CBO estimated that ACOs would save a net of \$1.7 billion for the federal government between 2013 and 2016, but a recent analysis suggests that after making shared savings payments and considering program cost, the MSSP ACOs had a net cost of [\\$384 million](#)

in that time.¹⁷ In 2017 and 2018, the MSSP achieved growing net savings, with one estimate of more than [\\$739 million](#) in 2018.¹⁸ It is possible that these trends will continue, as organizational and practice changes take hold. However, the program was [overhauled](#) significantly in July 2019 and the extent of future savings is unclear.¹⁹

Cadillac tax. While the ACA's cost containment provisions primarily targeted Medicare spending, it had elements that could have significantly affected long-term cost growth in the private sector. The most prominent was the "[Cadillac Tax](#)," structured to impose a 40% excise tax on high-cost employer-sponsored plans, beginning in 2018. The economic concept, sound in theory, was to counteract the tax incentive toward high-cost plans that drives overutilization of services. Although this provision had the greatest potential to bend the cost curve over time, Congress delayed implementation and finally repealed it in December 2019.²⁰

Individual marketplaces. Other cost containment reforms in the private market include the creation and regulation of [individual market exchanges](#).²¹ In theory, vibrant competition among plans could reduce the very high costs in the individual market. However, few marketplaces have attracted a sufficient number of plans to create the competition necessary to significantly reduce costs. And in the larger context, only [about 7%](#) of non-elderly people are in that market, limiting the potential of any individual market reform to significantly affect cost growth.²²

A TEN-YEAR LOOK

The ACA had many provisions designed to contain costs in both the short and long term. Two of the most promising and direct provisions to contain costs in the long term (IPAB and the Cadillac tax) have never been implemented. It appears that the ACA has had some success in slowing growth in Medicare costs (compared to private payers) through statutory reductions in payments to Medicare Advantage plans, and productivity adjustments that reduce annual provider payment updates. From 2010-2018, per capita Medicare spending rose an average of 1.7% annually, compared to 3.8% annually for private insurance.¹ However, the statutory reductions are not likely to be sustainable without significant changes in practice that go far beyond the ACA's ability to influence.

Although it does not appear that the ACA has "bent" the cost curve, changes in payment updates and productivity factors may be responsible for holding down growth in a post-recession recovery, at a time of expanded coverage for more than [20 million people](#).²³ That is perhaps all we could have expected from the legislation, given its implementation. Any further coverage expansions, and efforts toward universal coverage, will need to focus also on sustainable and long-term strategies to reduce the growth of health care costs.

REFERENCES

1. Tolbert, J., Orgera, K., Singer, N., & Damico, A. (2020). Key Facts about the Uninsured Population. *Kaiser Family Foundation Issue Brief*. Retrieved from <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>
2. Weiner, J., Marks, C., & Pauly, M. (2017). Effects of the ACA on Health Care Cost Containment. *LDI Issue Brief*. Retrieved from <https://ldi.upenn.edu/brief/effects-aca-health-care-cost-containment>
3. Martin, A.B., Hartman, M., Washington, B., & Catlin, A. (2017). National Health Spending: Faster Growth In 2015 as Coverage Expands and Utilization Increases. *Health Affairs*, 36(1), 166–176. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1330>
4. Health Spending Projections Through 2027. (2019). *Health Affairs Blog*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20190221.997607/full/>
5. The Centers for Medicare & Medicaid Services. (2012). *ACA Savings Report 2012*. Retrieved from <https://www.cms.gov/apps/files/ACA-savings-report-2012.pdf>
6. Shatto, J., & Clemens, M. (2019). *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*. Centers for Medicare & Medicaid Services. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2019TRAlternativeScenario.pdf>
7. The Medicaid and CHIP Payment and Access Commission. *Supplementary Payments*. Retrieved from <https://www.macpac.gov/subtopic/supplemental-payments/>
8. The Medicare Payment Advisory Commission. (2009). *Report to the Congress: Medicare Payment Policy*. Retrieved from <http://www.medpac.gov/docs/default-source/reports/march-2009-report-to-congress-medicare-payment-policy.pdf>
9. Skopec, L., Arons, J., & Zuckerman, S. (2019). Did Medicare Advantage Payment Cuts Affect Beneficiary Access and Affordability? *The American Journal of Managed Care*, 25(9): e261–e266.
10. Cubanski, J. & Neuman, T. (2017). FAQs: What's the Latest on IPAB? *Kaiser Family Foundation Issue Brief*. Retrieved from <https://www.kff.org/medicare/issue-brief/faqs-whats-the-latest-on-ipab/>
11. Spatz, I. (2018). IPAB RIP. *Health Affairs Blog*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20190221.997607/full/>
12. Glickman, A., Dinh, C., & Navathe, A.S. (2018). The Current State of Evidence on Bundled Payments. *LDI Issue Brief*. Retrieved from <https://ldi.upenn.edu/brief/current-state-evidence-bundled-payments>
13. Glickman, A. (2018). Value Based Payment: Is This Time Actually Different? *LDI Health PolicySense Blog*. Retrieved from <https://ldi.upenn.edu/healthpolicysense/value-based-payment-time-actually-different>
14. Navathe, A. S., et al. (2020). Spending and Quality After Three Years of Medicare's Voluntary Bundled Payment for Joint Replacement Surgery. *Health Affairs*, 39(1), 58–66.
15. Agarwal, R., Liao, J. M., Gupta, A., & Navathe, A.S. (2020). The Impact of Bundled Payment on Health Care Spending, Utilization, And Quality: A Systematic Review. *Health Affairs*, 39(1), 50–57.
16. The Centers for Medicare and Medicaid Services (2020). *Shared Savings Program Fast Facts*. Medicare Shared Savings Program. Retrieved from <https://www.cms.gov/files/document/2020-shared-savings-program-fast-facts.pdf>
17. Seidman, J., Feore, J., and Rosacker, N. (2018). *Medicare ACOs Have Increased Federal Spending Contrary to Projections That They Would Produce Net Savings*. Avalere. Retrieved from <https://avalere.com/press-releases/medicare-accountable-care-organizations-have-increased-federal-spending-contrary-to-projections-that-they-would-produce-net-savings>
18. Gonzalez-Smith, J., Bleser, W., Muhlestein, D., Richards, R., McClellan, M., & Saunders R. (2019). Medicare ACO Results for 2018: More Downside Risk Adoption, More Savings, and All ACO Types Now Averaging Savings. *Health Affairs Blog*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20191024.65681/full/>
19. Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017, 42 CFR 425 (2018). Retrieved from <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-27981.pdf>
20. Feiertag, T. (2020). Health Plan Sponsors Welcome Repeal of Cadillac Tax: Opportunities and Uncertainty Lie Ahead – SECURE Act Series. *The National Law Review*. Retrieved from <https://www.natlawreview.com/article/health-plan-sponsors-welcome-repeal-cadillac-tax-opportunities-and-uncertainty-lie-ahead>
21. Fehr, R., Cox, C. C. F., & Levitt, L. (2019). Data Note: Changes in Enrollment in the Individual Health Insurance Market through Early 2019. *Kaiser Family Foundation Issue Brief*. Retrieved from <https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/>
22. Health Insurance Coverage of Non-Elderly 0-64. *Kaiser Family Foundation State Health Facts*. Retrieved from <https://www.kff.org/other/state-indicator/nonelderly-0-64/>
23. *Chart Book: Accomplishments of Affordable Care Act*. (2019). Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act>

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Since 1967, the University of Pennsylvania's Leonard Davis Institute of Health Economics (Penn LDI) has been the leading university institute dedicated to data-driven, policy-focused research that improves our nation's health and health care. Penn LDI works on issues concerning aging, vulnerable populations, access and coverage, and the opioid epidemic. Penn LDI connects all twelve of Penn's schools, the University of Pennsylvania Health System, and the Children's Hospital of Philadelphia through its more than 300 Senior Fellows.

COLONIAL PENN CENTER
3641 LOCUST WALK
PHILADELPHIA, PA 19104-6218
LDI.UPENN.EDU

P: 215-898-5611

F: 215-898-0229

 @PENNLDI

AUTHOR

Janet Weiner, PhD, MPH
Co-Director for Health Policy
Leonard Davis Institute of Health Economics
University of Pennsylvania