THE HENRY J. KAISER FAMILY FOUNDATION

Filling the need for trusted information on national health issues...

December 2016 | Issue Brief

What Are the Implications of Repealing the Affordable Care Act for Medicare Spending and Beneficiaries?

Juliette Cubanski, Tricia Neuman, Gretchen Jacobson, and Cristina Boccuti

The 2010 Affordable Care Act (ACA) included many provisions affecting the Medicare program and the 57 million seniors and people with disabilities who rely on Medicare for their health insurance coverage. Such provisions include reductions in the growth in Medicare payments to hospitals and other health care providers and to Medicare Advantage plans, benefit improvements, payment and delivery system reforms, higher premiums for higher-income beneficiaries, and new revenues.

President-elect Donald Trump, Speaker of the House Paul Ryan, Health and Human Services (HHS) Secretary-nominee and current House Budget Committee Chairman Tom Price, and many other Republicans in Congress have proposed to repeal and replace the ACA, but lawmakers have taken different approaches to the ACA's Medicare provisions. For example, the House Budget Resolution for Fiscal Year 2017, introduced by Chairman Price in March 2016, proposed a full repeal of the ACA. The House Republican plan, "A Better Way," introduced by Speaker Ryan in June 2016, proposed to repeal some, but not all, of the ACA's Medicare provisions.

This brief explores the implications for Medicare and beneficiaries of repealing Medicare provisions in the ACA. The Congressional Budget Office (CBO) has estimated that full repeal of the ACA would increase Medicare spending by $802 billion from 2016 to 2025.[1] Full repeal would increase spending primarily by restoring higher payments to health care providers and Medicare Advantage plans. The increase in Medicare spending would likely lead to higher Medicare premiums, deductibles, and cost sharing for beneficiaries, and accelerate the insolvency of the Medicare Part A trust fund. Policymakers will confront decisions about the Medicare provisions in the ACA in their efforts to repeal and replace the law.

What are the key Medicare provisions in the ACA and how would repeal affect Medicare spending and beneficiaries?

The following discussion highlights several of the key Medicare provisions in the ACA and assesses how repeal of these provisions could affect Medicare spending and beneficiaries.[2]

Payments to Health Care Providers

The ACA reduced updates in Medicare payment levels to hospitals, skilled nursing facilities, hospice and home health providers, and other health care providers. The ACA also reduced Medicare Disproportionate Share Hospital (DSH) payments that help to compensate hospitals for providing care to low-income and uninsured patients, with the expectation that hospitals would have fewer uninsured patients as a result of the ACA's coverage expansions.

Repealing the ACA's sustained reductions in provider payments would be expected to:

- **Increase Part A and Part B spending.** CBO has estimated that roughly $350 billion[3] of the total $802 billion in higher Medicare spending over 10 years could result from repealing ACA provisions that changed provider payment rates in traditional Medicare. Repealing these provisions would increase payments to providers in traditional Medicare. Additionally, some hospitals would receive higher DSH payments, if these payments were restored to their pre-ACA levels.
- **Increase the Part A deductible and copayments and the Part B premium and deductible paid by beneficiaries.** The Part A deductible and copayments would be expected to increase due to an increase in Part A spending that would likely occur if payment reductions are repealed. This is because the Part A deductible for inpatient hospital stays is indexed to updates in hospital payments, and the copayment amounts for inpatient hospital and skilled nursing facility stays are calculated as a percentage of the Part A deductible. Similarly, the Part B premium and deductible would be expected to increase if payments to Part B service providers are restored. This is because Part B premiums are set to cover 25 percent of Part B spending, and the Part B deductible is indexed to rise at the same rate as the Part B premium.

Payments to Medicare Advantage Plans

Prior to the ACA, federal payments to Medicare Advantage plans per enrollee were 14 percent higher than the cost of covering similar beneficiaries under the traditional Medicare program, according to the Medicare Payment Advisory Commission (MedPAC).[4] The ACA reduced payments to Medicare Advantage plans over six years, which brought these payments closer to the average costs of care under the traditional Medicare program. In 2016, federal payments to plans were 2 percent higher than traditional Medicare spending (including quality-based bonus payments to plans).[5]

Repealing the ACA's Medicare Advantage payment changes would be expected to:

- **Increase total Medicare spending as a result of increasing payments to Medicare Advantage plans relative to spending under traditional Medicare.** CBO has estimated that repealing the Medicare Advantage-related provisions in the ACA would increase Medicare spending by roughly $350 billion[6] (out of the $802 billion total increase) over 10 years.
- **Increase the Part B premium and deductible paid by beneficiaries.** The Part B premium and deductible would likely increase if the payment reductions for Medicare Advantage plans are repealed because the Part B premium is set to cover 25 percent of Part B spending, and the Part B deductible is indexed to rise at the same rate as the Part B premium.
- **Improve benefits and lower out-of-pocket costs for beneficiaries enrolled in Medicare Advantage plans.** Payments that Medicare Advantage plans receive in excess of their costs to provide Part A and Part B benefits are required to be used to provide benefits not covered by traditional Medicare, to reduce cost sharing, premiums, or limits on out-of-pocket spending, or both. Thus, if the ACA's reductions in Medicare Advantage plan payments were repealed, plans could provide extra benefits to Medicare Advantage enrollees and/or reduce enrollees' costs.

Medicare Benefit Improvements

The ACA included provisions to improve Medicare benefits by providing free coverage for some preventive benefits, such as screenings for breast and colorectal cancer, cardiovascular disease, and diabetes, and closing the coverage gap (or "doughnut hole") in the Part D drug benefit by 2020. These benefit improvements increased Medicare Part B and Part D spending.

Repealing the ACA's Medicare benefit improvements would be expected to:

- **Reduce Medicare Part B spending for preventive services and reduce Part D spending on costs in the coverage gap.**
- **Increase beneficiary cost sharing for Part B preventive benefits.**
- **Increase beneficiary cost sharing by Part D enrollees who have drug spending high enough to reach the coverage gap.** According to MedPAC, in 2013, roughly 25 percent of the 37.8 million Part D enrollees (or around 9 million beneficiaries) had drug spending high enough to reach the coverage gap.[7,8]
- **Reduce Part D premiums,** on average, since Part D premiums are set to cover 25.5 percent of program costs, and reinstating the Part D coverage gap would lower Part D spending.

Revenues to the Medicare Trust Funds

The ACA established new sources of revenue dedicated to the Medicare program, including a 0.9 percentage point increase in the Medicare Part A payroll tax on earnings of higher-income workers (incomes more than $200,000/individual and $250,000/couple), and a fee on the manufacturers and importers of branded drugs, which has generated additional revenue for the Part B trust fund, including $3 billion in 2015 alone.[9]

Repealing the ACA's Medicare revenue provisions would be expected to:

- **Reduce revenues to Medicare's Part A and Part B trust funds.**
- **Reduce Part A payroll taxes for Medicare beneficiaries (and other taxpayers) with earnings greater than $200,000/individual or $250,000/couple.**

Medicare Part B and Part D Premiums for Higher-Income Beneficiaries

The ACA froze the income thresholds for the Part B income-related premium beginning at $85,000/individual and $170,000/couple through 2019, which subjected a larger share of Medicare beneficiaries to the higher Part B income-related premium over time.[10] The law also added a new surcharge to Part D premiums for higher-income enrollees, using the same income thresholds as Part B premiums.

Repealing the ACA's income-related premium provisions would be expected to:

- **Reduce the number of higher-income Part B enrollees paying income-related premiums.**
- **Reduce Part D premiums for beneficiaries with incomes above $85,000/individual and $170,000/couple.**

Payment and Delivery System Reforms and New Quality Incentives

Through a new Center for Medicare & Medicaid Innovation (CMMI, or Innovation Center) within the Centers for Medicare & Medicaid Services (CMS), the ACA directed CMS to test and implement new approaches for Medicare to pay doctors, hospitals, and other providers to bring about changes in how providers organize and deliver care. The ACA authorized the Secretary of Health and Human Services to expand CMMI models into Medicare if evaluation results showed that they either reduced spending without harming the quality of care or improved the quality of care without increasing spending. CMMI received an initial appropriation of $10 billion in 2010 for payment and delivery system reform model development and evaluation, and the ACA called for additional appropriations of $10 billion in each decade beginning in 2020.

The ACA also created incentives for hospitals to reduce preventable readmissions and hospital-acquired conditions, and established new accountable care organizations (ACO) programs. Research has shown declines in Medicare patient readmissions since the Hospital Readmission Penalty Program provisions were introduced.

Repealing these ACA's payment and delivery system reform provisions would be expected to:

- **Increase Medicare spending due to elimination of CMMI and other quality incentive programs.** On net, CBO has estimated that CMMI's operations will generate savings of $34 billion over the 2017-2026 period, with gross savings of $45 billion over this period. These savings are attributed to the expansion of successful payment and delivery system reform models into Medicare. In addition to eliminating the savings generated from CMMI, Medicare spending could also increase if the incentives to reduce preventable readmissions and hospital-acquired conditions are included in proposals to repeal and replace the ACA.

Independent Payment Advisory Board

The ACA authorized a new Independent Payment Advisory Board (IPAB), a 15-member board that is required to recommend Medicare spending reductions to Congress if projected spending growth exceeds specified target levels, with the recommendations taking effect according to a process outlined in the ACA. To date, no members have been appointed to the Board. Many policymakers have expressed opposition to IPAB, and there have been several legislative attempts to eliminate it. The CMS Office of the Actuary has estimated that the IPAB process will first be triggered in 2017, based on its most recent Medicare spending growth rate projections.[11]

Repealing IPAB would be expected to:

- **Increase Medicare spending over time, in the absence of the Board's cost-reducing actions.** CBO projects Medicare savings of $8 billion as a result of the IPAB process between 2019 and 2026.[12]

How would ACA repeal affect the solvency of the Medicare Hospital Insurance trust fund?

Fully repealing the ACA would accelerate the projected insolvency of the Medicare Hospital Insurance (HI) trust fund, out of which Part A benefits are paid. This would result from higher spending for Part A services due to higher payments to Part A service providers (such as hospitals) and Medicare Advantage plans for services provided under Part A, along with reduced revenues, if the additional 0.9 percent payroll tax on high earners is repealed. As a result, Medicare would not be able to fulfill its obligation to pay for all Part A-covered benefits within a shorter period of time if the ACA is repealed than if the law is retained.

Prior to enactment of the ACA in 2010, the Medicare Trustees projected that the Part A trust fund would not have sufficient funds to pay all Part A benefits beginning in 2017. Following enactment of the law, the insolvency date was extended. The current insolvency date is projected to be 2028. Repealing the ACA is expected to push up the insolvency date.

Discussion

The Medicare provisions of the ACA have played an important role in strengthening Medicare's financial status for the future, while offsetting some of the cost of the coverage expansions of the ACA and also providing some additional benefits to people with Medicare. Savings were achieved in part by reducing payments to providers, such as hospitals and skilled nursing facilities. Medicare provider payment changes in the ACA were adopted in conjunction with the ACA's insurance coverage expansions, with the expectation that additional revenue from newly-insured Americans would offset lower revenue from Medicare payments. In addition, Medicare savings were achieved through lower payments to Medicare Advantage plans.

Congressional action to repeal the ACA appears imminent, but it is not yet clear whether Congress will repeal the ACA in its entirety or keep certain provisions in place. Previous Congressional proposals have taken different approaches. For example, the House Budget Resolution for Fiscal Year 2017, introduced by Chairman Price in March 2016, proposed a full repeal of the ACA. The House Republican plan, "A Better Way," introduced by Speaker Ryan in June 2016, proposed to repeal some of the ACA's Medicare Advantage payment changes, along with repealing IPAB and CMMI, the additional Medicare payroll tax on high earners, and certain other tax and revenue provisions, but appears to retain other Medicare provisions, including changes to provider payment updates and the benefit improvements.[13]

A majority of Americans have expressed support for some of the ACA provisions that affect Medicare, including the elimination of out-of-pocket costs for many preventive services, closing the Part D coverage gap, and the higher Medicare payroll tax for higher-income workers.[14] Some industry stakeholders have expressed concern about the implications of retaining the ACA's savings provisions, yet repealing the ACA's coverage expansions.

Aside from uncertainty about whether any of the ACA's Medicare provisions will be retained, questions have arisen as to what changes policymakers could advance through the legislative process known as "reconciliation." Policymakers are considering repealing the ACA as part of budget reconciliation legislation, which requires only a simple majority in the Senate to pass. Senate rules (the so-called "Byrd Rule") limit the scope of reconciliation legislation to provisions with budgetary effects, including spending and revenues. Most of the Medicare provisions in the ACA have budgetary effects, according to CBO, so would likely be considered in order in the context of a reconciliation bill.

As a result of the Medicare provisions included in the ACA, Medicare spending per beneficiary has grown more slowly than private health insurance spending; premiums and cost-sharing for many Medicare-covered services are lower than they would have been without the ACA; new payment and delivery system reforms are being developed and tested; and the Medicare Part A trust fund has gained additional years of solvency. Full repeal of the Medicare provisions in the ACA would increase payments to hospitals and other health care providers and Medicare Advantage plans, which would likely lead to higher premiums, deductibles, and cost sharing for Medicare-covered services paid by people with Medicare. Full repeal would also reduce premiums for higher-income beneficiaries, and reduce payroll tax contributions from beneficiaries (and other taxpayers) with high earnings. Repealing the ACA would have uncertain effects on evolving payment and delivery system reforms. Partial repeal of the law could also have implications for Medicare spending, the Part A trust fund solvency date, and beneficiaries' costs. Policymakers who seek to repeal the ACA may need to address the implications for Medicare, beneficiaries, and other stakeholders.

Endnotes

[1] Congressional Budget Office, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015, available at https://www.cbo.gov/publication/50252.

[2] This discussion does not include the ACA provision to eliminate the tax deductibility of the 28 percent federal subsidy, known as the retiree drug subsidy (RDS), for employers who provide creditable prescription drug coverage to Medicare beneficiaries. Repealing this provision would not have a direct effect on Medicare spending but, in allowing for the tax deductibility of RDS payments, would be accounted for as a federal tax expenditure.

[3] This $350 billion estimate is calculated from CBO's statement that roughly one-half of the net increase in direct spending ($715 billion, between 2016 and 2025) would stem from repealing provisions that changed payment rates in the fee-for service sector. Congressional Budget Office, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015, available at https://www.cbo.gov/publication/50252.

[4] Medicare Payment Advisory Commission (MedPAC) "Report to the Congress: Medicare Payment Policy," March 2009, available at http://www.medpac.gov/docs/default-source/reports/mar09_ch03.pdf.

[5] Medicare Payment Advisory Commission (MedPAC) "Report to the Congress: Medicare Payment Policy," March 2016, available at http://www.medpac.gov/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report-.pdf.

[6] This $350 billion estimate is calculated from CBO's statement that roughly one-half of the net increase in direct spending ($715 billion, between 2016 and 2025) would stem from repealing provisions that changed the rules for setting payment rates for Medicare Advantage plans. Congressional Budget Office, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015, available at https://www.cbo.gov/publication/50252.

[7] Medicare Payment Advisory Commission (MedPAC) "Report to the Congress: Medicare Payment Policy," March 2016, available at http://www.medpac.gov/docs/default-source/reports/chapter-13-status-report-on-part-d-march-2016-report-.pdf.

[8] According to CMS estimates, more than 11 million Medicare Part D enrollees have received a total of $23.5 billion in savings and discounts in the coverage gap since the enactment of the ACA, with savings averaging $2,127 per enrollee over five years. See Centers for Medicare & Medicaid Services, "Medicare Advantage Premiums Remain Stable in 2017; Beneficiaries Have Saved over $23.5 Billion on Prescription Drugs," September 22, 2016, available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-09-22.html.

[9] Table III.C1, Statement of the Operations of the Part B Account in the SMI Trust Fund during Calendar Year 2015, 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 2016, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf.

[10] The Part B income-related premium was established by the Medicare Modernization Act of 2003 and took effect in 2007. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made further changes to Medicare's income-related premiums requiring beneficiaries with incomes above $133,500 ($267,000 for married couples) to pay a larger percentage of Part B and Part D program costs than they currently pay, beginning in 2018. MACRA also included a provision to index the thresholds to inflation based on their levels in 2019.

[11] Table V.B2: Key Rates of Growth for IPAB Determination, 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 2016, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf.

[12] Congressional Budget Office (CBO), "March 2016 Medicare Baseline," March 24, 2016, available at https://www.cbo.gov/sites/default/files/51302-2016-03-Medicare.pdf.

[13] See also, "A Better Way Frequently Asked Questions," available at http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-FAQ.pdf.

[14] Ashley Kirzinger, Elise Sugarman, and Mollyann Brodie, "Kaiser Health Tracking Poll: November 2016," Kaiser Family Foundation, December 2016, available at http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2016/.