Medicare: Changes Made by the Reconciliation Act of 2010 to the Patient Protection and Affordable Care Act (P.L. 111-148)

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Summary

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), which would, among other changes, make statutory changes to the Medicare program. The U.S. House of Representatives also passed an amendment in the nature of a substitute to H.R. 4872, the Health Care and Education Affordability Reconciliation Act of 2010, on March 21, 2010 (referred to hereafter as the Reconciliation bill), which would amend the PPACA.

The Reconciliation bill includes two titles. The first title contains provisions related to health care and revenues, including modifications to PPACA's Medicare provisions. The second title includes amendments to the Higher Education Act of 1965, which authorizes most of the federal programs involving postsecondary education.

Medicare changes that would be made by the Reconciliation bill, as passed by the House on March 21, 2010, to the PPACA are summarized in this report. Among other changes, the Reconciliation bill would:

- phase out the coverage gap under the Medicare prescription drug benefit and close it by 2020;
- change the methodology used to determine Medicare Advantage payments, and create an incentive system to reward high quality plans with higher payments;
- move up reductions in payments to disproportionate share hospitals to 2014, and reduce the cuts;
- revise the adjustments to annual updates for certain providers;
- change the qualifying date whereby an existing physician-owned hospital would be exempt from the self-referral prohibition;
- change the assumptions used to calculate Medicare reimbursement for advanced imaging services; and
- increase funding for the Health Care Fraud Abuse Control program and provide for enhanced oversight of DME suppliers.

This report will be updated as legislative activity warrants.

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Introduction

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148).[1] The Act contains numerous provisions affecting Medicare payments, payment rules, covered benefits, and the delivery of care. The U.S. House of Representatives also passed an amendment in the nature of a substitute to H.R. 4872, the Health Care and Education Affordability Reconciliation Act of 2010, on March 21, 2010.[2] The Reconciliation bill would amend PPACA and would make changes to a number of Medicare-related provisions in that Act.

The Reconciliation bill includes two titles. The first title contains provisions related to health care and revenues. Subtitle B of Title I contains provisions that would modify provisions in the PPACA related to Medicare fee-for-service, Medicare Advantage, and Medicare outpatient prescription drug programs. Subtitle D contains provisions related to reducing waste, fraud and abuse in Medicare. Subtitle E contains revenue related provisions including a provision that would make changes to the Medicare tax provision in PPACA. The second title includes amendments to the Higher Education Act of 1965, which authorizes most of the federal programs involving postsecondary education.

Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) Scores

On March 20, 2010, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) issued cost estimates of the PPACA as amended by the Reconciliation bill.[3] Their analyses provide estimates of the direct spending and revenue effects of the combined bills.[4]

CBO estimated that total mandatory annual expenditures for Medicare prior to PPACA would grow from $501 billion in 2009 to $943 billion in 2019.[5] Cumulative spending for the years 2010 to 2019 was expected to exceed $7 trillion. CBO estimates that the provisions in the PPACA as amended by the Reconciliation bill that would affect the Medicare, Medicaid, Children's Health Insurance and other federal programs would reduce direct spending by $511 billion over the FY2010-FY2019 period.[6] Medicare (absent interaction effects) accounts for approximately

[1] The full text of the Patient Protection and Affordable Care Act, as enacted, is at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf.

[2] The full text of H.R. 4872, as passed by the House, is at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872eh.txt.pdf.

[3] The CBO score on the Reconciliation bill, H.R. 4872 combined with PPACA, may be found at http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf. The JCT score may be found at http://www.jct.gov/publications.html?func=startdown&id=3672.

[4] These estimates are based on the Reconciliation bill issued on March 18, 2010, as modified by subsequent changes by the manager's amendment that was made public on March 20, 2010.

[5] CBO's Baseline Projections of Medicare Spending, March 2009, http://www.cbo.gov/budget/factsheets/2009b/medicare.pdf.

[6] The estimated overall effect of the proposed legislation is a net decrease in the federal budget deficit of $143 billion over the FY2010-FY2019 period. The projected 10-year cost of increasing insurance coverage of $788 billion is offset by the net spending decrease of $511 billion and by revenue provisions that are estimated to raise $420 billion over the (continued...)

$390 billion of the reduction.[7] Total Medicare reductions in direct spending over the 10-year period are estimated to be about $460 billion, but these reductions would be offset by Medicare payment increases of close to $70 billion.[8]

The estimated Medicare savings from the PPACA as amended by the Reconciliation bill are about $10 billion less than the estimated Medicare savings of $400 billion for PPACA alone.[9] The differences in projected Medicare savings are primarily due to changes that led to reductions in cost savings estimates for provisions related to disproportionate share hospitals and the Independent Payment Advisory Board together with cost increases associated with closing the coverage gap in the outpatient prescription drug benefit. A portion of the projected cost increases is offset by increases in savings estimates of provisions related to the Medicare Advantage program, productivity adjustments for certain inpatient services, and advanced imaging services. Changes by the Reconciliation bill to the Medicare tax provision in PPACA are estimated to raise an additional $123 billion above the $87 billion raised in PPACA, for a total of $210 billion in added revenue over 10 years.

Key Changes Made to PPACA by the Reconciliation Bill

The Medicare provisions in Subtitles B, D and E of Title I in the Reconciliation bill would make modifications to certain Medicare provisions in PPACA, as well as add several new provisions. Below are summaries of how the Reconciliation bill, H.R. 4872, would change, or add to, Medicare-related provisions in PPACA together with descriptions of applicable law in effect prior to the enactment of PPACA.[10]

Changes Affecting Medicare Fee-For-Service Providers

Medicare Disproportionate Share Hospital (DSH) Payments

Provisions in the PPACA (Sec. 3133 as modified by Sec. 10316) reduce the amount of disproportionate share hospital (DSH) payments that are provided to hospitals by 75% (which represents an empirically justified amount) starting in FY2015. Hospitals are to receive additional payments based on a formula that incorporates certain factors including the reduction in their

(...continued)

same period.

[7] CRS analysis of CBO March 20, 2010, estimates of the effects of the Reconciliation bill and PPACA combined (http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf).

[8] CBO expenditure projections for the PPACA do not include all of the discretionary costs that would be associated with the legislation. CBO expects Department of Health and Human Services costs to increase at least $5 billion to $10 billion over 10 years.

[9] For more details on the Medicare savings estimate for PPACA, see CRS Report R40970, *Medicare Program Changes in Senate-Passed H.R. 3590*.

[10] See CRS Report R40970, *Medicare Program Changes in Senate-Passed H.R. 3590*, coordinated by (name redact ed), for additional detail on how PPACA would change the Medicare program, on specific Medicare provisions in PPACA, and on the projected budgetary impact of these provisions.

DSH funds, the percentage change in the uninsured under-65 population, and the relative share of uncompensated care provided by the hospital.

The Reconciliation bill (Sec. 1104) would implement the DSH changes in FY2014 and modify one of the factors in the formula (regarding the change in the uninsured under-65 population) used to distribute the additional DSH payments. Specifically, under the PPACA provision, from FY2015 through FY2018, hospital payments will reflect the difference in the percentage change in the uninsured under-65 population from 2013 to the most recent period minus 1.5 percentage points; in subsequent years, the payments would be based on the percentage difference in the uninsured (without the subtraction). Under reconciliation language, the percentage subtraction would be 0.1 percentage points in FY2014, and 0.2 percentage points in FY2015 through FY2019. *According to CBO's estimate, the Reconciliation bill would increase DSH spending by $3 billion over 10 years—the score for the combined bills is -$22.2 billion for FY2010-FY2019 compared to a score of -$25 billion for PPACA alone.*

Revisions to Certain Market Basket Reductions

Provisions in the PPACA (Sec. 3401 as modified by Sec. 10319) implement a full productivity adjustment for inpatient and outpatient hospital services (IPPS and OPPS respectively), inpatient psychiatric facilities (IPFs), inpatient rehabilitation (IRFs), and long term care hospital (LTCHs) services (and other providers) beginning in FY2012. The update factors for Medicare providers and suppliers will also be subject to additional adjustments. The Reconciliation bill (Sec. 1105) would revise the additional adjustments to the market basket (MB) updates for the IPPS, OPPS, IPF, IRF and LTCH payment systems. Instead of reducing the MB updates by 0.2 percentage points each year from 2014 through 2019 depending upon the level of the insured nonelderly population in relationship to the estimated level of insured, the MB would be reduced by 0.3 percentage points in FY2014, by 0.2 percentage points in FY2015 and FY2016, and by 0.75 percentage points in FY2017 through FY2019. *CBO estimates that this change would decrease Medicare spending by $9.9 billion over 10 years—from a score of -$146.7 billion over FY2010-FY2019 for the PPACA to -$156.6 billion for PPACA and H.R. 4872 combined.*[11]

Physician Ownership-Referral

Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have an ownership or investment interest. However, among other exceptions, this prohibition does not apply to physicians with ownership or investment interests in a whole hospital. Provisions in the PPACA (Sec. 6001 as modified by Sec. 10601) exempt only those physician-owned hospitals meeting certain requirements from the self-referral prohibition beginning no later than 18 months after the date of enactment. Specifically, hospitals that have physician ownership and a provider agreement in operation on August 1, 2010, and that met other specified requirements will be exempt from this self-referral ban. The Reconciliation bill (Sec. 1106) would change the target date to December 31, 2010, along with certain conforming changes. The PPACA provisions also establish a process to allow certain physician-owned hospitals to expand in a limited fashion. The reconciliation

[11] Due to an interaction effect between this change and Section 3403 of PPACA concerning the Independent Medicare Advisory Board, the CBO estimated savings associated with Section 3403 decreased by $12.6 billion over 10 years (from a score of -$28 billion over 10 years for PPACA alone to a score of -$15.5 billion for the combined bills).

provision would allow grandfathered physician-owned hospitals that are not the only hospital in their county that treat the highest percentage of Medicaid patients in their county to expand. *CBO estimates that this change would increase Medicare spending by $0.1 billion over 10 years—from a score of -$0.5 billion for the PPACA for FY2010-FY2019 to -$0.5 billion for the PPACA and H.R. 4872 combined.*[12]

Payment for Qualifying Hospitals

The Reconciliation bill as modified by the manager's amendment (Sec. 1109) would provide $400 million for two years (FY2011 and FY2012) to increase Medicare's payments to acute care hospitals in low-cost counties. The qualifying hospitals are located in counties ranked in the lowest quartile of adjusted Medicare Part A and B spending (adjusted by age, sex, and race). Additional payments to each qualifying hospital would be in proportion to its Medicare inpatient hospital payments relative to Medicare inpatient hospital payments for all qualifying hospitals. *CBO estimates that this provision would increase Medicare spending by a total of $400 million from FY2011 through FY2012* .

Payment for Imaging Services

The 2010 final rule for payments to providers under the Medicare fee schedule as published in the Federal Register on November 25, 2009, uses an assumption that advanced imaging equipment (such as MRIs) is being used 90% of the time (up from 50% in prior years), following a MedPAC recommendation based on studies that surveyed the actual use of the equipment. Section 3135 of the PPACA changes the utilization rate assumption for calculating the payment for advanced imaging equipment from 50% to 65% for 2010 through 2012. The rate will be further increased to 70% for services provided in 2013 and 75% for services provided in 2014. Sec. 1107 of the Reconciliation bill would set the utilization rate at 75% in 2011 and in subsequent years. *CBO estimates that this change to Section 3135 would increase cost savings by $1.2 billion over 10 years—from -$1.1 billion over 10 years for PPACA to -$2.3 billion over 10 years for PPACA and H.R. 4872 combined.*

Physician Fee Schedule: Geographic Cost Indices

The Medicare physician fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices—known as Geographic Practice Cost Indices (GPCIs)—that reflect how each area compares to the national average in a "market basket" of goods. A value of 1.00 represents an average across all areas. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004; most recently, Section 134 of the MIPPA extended the application of this floor when calculating Medicare physician reimbursement through December 2009.

Section 3102 of PPACA directs the Secretary to adjust the practice expense GPCI for 2010 to reflect three-fourths of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e., a blend of three-fourths local and one-fourth national) instead of the full difference under prior law. For 2011, the

[12] The combined score did not increase due to rounding.

adjustment is to reflect one-half of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e., a blend of one-half local and one-half national). The manager's amendment to the Reconciliation bill (Sec. 1108) modifies the adjustment for 2010 so that the PE GPCI would reflect one-half of the difference for both 2010 and for 2011. *CBO estimates that this change to Section 3102 of PPACA would increase 10-year costs by $0.4 billion—from a score of $1.8 billion for PPACA over 10 years to a score of $2.2 billion for PPACA and H.R. 4872 combined.*

Changes Affecting the Medicare Advantage (MA) Program

The Reconciliation bill would change the way payments to MA plans are calculated, tying the maximum possible payment (the MA benchmark) to a percentage of spending in original Medicare—a provision which may reduce benchmarks in many areas. However, the bill would also increase benchmarks and vary plan rebates by plan quality. The Reconciliation bill would also repeal the Comparative Cost Adjustment (CCA) program, and would require plans to spend a minimum amount of revenue on patient care, or pay a fine.

MA payments are determined by comparing a plan's cost of providing required Medicare benefits (bid) to the maximum amount Medicare will pay for those benefits in each area (benchmark). If a plan bid is below the benchmark, the plan is paid its bid plus a rebate equal to 75% of the difference between the bid and the benchmark. If a plan bids above the benchmark, the plan is paid the benchmark and must charge each enrollee a premium equal to the difference between the bid and the benchmark. Historically, Congress has increased the benchmarks through statutorily specified formulas, in part, to encourage plan participation throughout the country. As a result, the benchmarks in some areas are higher than average spending in original fee-for-service Medicare.

Section 1102 of the Reconciliation bill would repeal Section 3201 of PPACA and replace it with a different methodology for determining MA payments. Under the Reconciliation bill, the benchmarks in 2011 would be held at the 2010 levels. In 2012, the Reconciliation bill would begin to phase in blended benchmarks based on a percentage (95%, 100%, 107.5%, or 115%) of a base amount. In 2012, the base amount would be set at per-capita spending in original Medicare; after 2012, the base amount would be either the previous year's base amount increased by the growth in overall Medicare, or per capita spending in original Medicare in that county. The percentage adjustment to the base amount would be lower (95%) in counties where spending in original Medicare is the highest, and higher (115%) in counties where spending in original Medicare is the lowest. The phase-in schedule for the new benchmarks would vary over two, four, or six years depending on the size of the benchmark reduction, with a longer phase-in schedule for areas where the benchmark decreases by larger amounts. The new blended benchmarks would not apply to PACE plans.

Under current law, MA plans are required to have quality improvement programs; however, MA payments are not contingent on plan quality. Under the Reconciliation bill,[13] starting in 2012, qualifying plans would receive an increase in their blended benchmark, with larger increases for qualifying plans in qualifying areas. A qualifying plan would be one with a 4-star or higher rating on a 5-star rating scale established by the Secretary. Plans with low enrollment or new plans could also be qualifying plans. A qualifying county would be a county with (1) lower than

[13] Section 3201 of the PPACA includes provisions which would provide extra payments (as opposed to adjustments to the benchmark) for plan quality and care coordination. This section would be repealed by the Reconciliation bill.

average per capita spending in original Medicare, (2) 25% or more beneficiaries enrolled in MA, as of December 2009, and (3) a Medicare payment rate to private plans based on the minimum payment for a metropolitan statistical area (urban floor rate) in 2004, based on the payment methodology at the time. Under the Reconciliation bill, a plan's quality rating would also affect the size of the rebate it could receive; plans with higher quality ratings would receive higher rebates, with new rebates ranging from 50% to 70% of the difference between the bid and the benchmark. The change in rebate percentages would be phased in over three years.

The Reconciliation bill would repeal Section 3203 of PPACA, a provision that would grant the Secretary the *authority* to expand the use of coding intensity adjustments beyond 2010, and replace it with an alternative provision. A coding intensity adjustment is an adjustment to plan payments to account for the way diagnosis coding of patients differs between MA plans and original Medicare.[14] The Reconciliation bill (Section 1102e) would instead *require* the Secretary to apply coding intensity adjustments after 2010. The bill would also set minimum adjustments starting in 2014, to be applied until the Secretary implements risk adjustment using MA diagnostic, cost, and use data.

The requirement for a six-year program to examine comparative cost adjustment (CCA)[15] in designated CCA areas would be repealed by the Reconciliation bill. Specifically this program requires that payments to local MA plans in CCA areas would, in part, be based on competitive bids (similar to payments for regional MA plans), and Part B premiums for individuals enrolled in traditional Medicare may be adjusted, either up or down.

A Medical Loss Ratio (MLR) identifies the proportion of a plan's premium revenue that the plan devotes to the provision of health care services. The remaining proportion represents the amount spent on managing the plan, including administrative costs, advertising, and profits. Beginning in 2014, Section 1103 of the Reconciliation bill would require plans that have an MLR of less than .85 to remit to the Secretary a payment equal to their total revenue multiplied by the difference between .85 and their MLR. The Secretary would be required to restrict enrollment in an MA plan if its MLR was below .85 for three consecutive years and terminate the plan's contract if the plan failed to meet the MLR requirements for five consecutive years.

CBO estimates that the changes to the MA program included in the Reconciliation bill would decrease 10-year costs by $17.0 billion relative to the MA provisions included in PPACA alone—from -$118.1 billion over 10 years for PPACA to -$135.6 billion over 10 years for the combined bills.[16]

[14] In general, MA plan payments are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Deficit Reduction Act of 2005 (P.L. 109-171, DRA) required the Secretary to adjust for patterns of diagnosis coding differences between MA plans and providers under parts A and B of Medicare for plan payments in 2008, 2009, and 2010.

[15] The Comparative Cost Adjustment (CCA) program was required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-132) to: (1) examine a new MA payment system under which payments to MA plans would be based on a weighted average of plans bids; and (2) introduce possible adjustments (either increases or decreases) to fee-for-service Part B premiums, based on a comparison of the costs of providing required fee-for-service benefits to the costs of providing the same benefits in the MA program.

[16] This difference takes into account changes in payment policy (a difference of -$17.5 over 10-years and an additional cost of $0.7 billion over 10-years to repeal the coding intensity provision in PPACA) as well as interaction effects (a difference of -$0.2 billion).

Changes to the Medicare Part D Outpatient Prescription Drug Benefit

Medicare law sets out a defined standard benefit structure under the Part D prescription drug benefit that includes a gap in coverage, commonly referred to as the "doughnut hole." In 2010, the standard benefit includes a $310 deductible and a 25% coinsurance until the enrollee reaches $2,830 in total covered drug spending (Medicare and beneficiary spending combined). After this initial coverage limit is reached, the enrollee is responsible for the full cost of the drugs until total costs hit the catastrophic threshold, $6,440 in 2010. In general, in 2010, Part D enrollees who do not receive assistance in the form of the Part D low-income subsidy would be responsible for a total of $4,550 in out-of-pocket costs before reaching the catastrophic phase ($310 deductible, $630 in co-insurance in the initial coverage phase, and $3,610 in the coverage gap).[17]

PPACA makes a number of changes to the Medicare Part D program including requiring, consistent with a voluntary agreement with the pharmaceutical industry, that beginning July 1, 2010, drug manufacturers provide certain Part D enrollees with discounts of 50% for brand name drugs during the coverage gap (Section 3301). Plan enrollees receiving the low income subsidy enrolled in an employee–sponsored retiree drug plan, or with annual incomes that exceed the Part B income thresholds as determined under current law, will not be eligible for the discount. PPACA also would increase the initial coverage limit by $500 in 2010 (Section 3315).

The Reconciliation bill (Section 1101) would repeal Section 3315 of PPACA, and, instead of increasing the coverage limit by $500, the bill would provide rebates of $250 to Part D enrollees who enter the coverage gap in 2010. Additionally, under the Reconciliation bill the discount would begin January 1, 2011, instead of July 1, 2010, and higher income enrollees would be eligible to receive the discount. The Reconciliation bill would also phase out the Part D coverage gap. Specifically, the bill would gradually reduce the amount of enrollee cost sharing for both generic and brand name drugs through the coverage gap; in 2020 and beyond, beneficiary cost sharing would equal or be actuarially equivalent to 25% (similar to cost sharing during the initial coverage phase). Additionally, the bill would slow the rate of growth of the catastrophic coverage limit from 2014 through 2019. The beneficiary co-payments and the value of the manufacturer discount for brand name drugs would count towards the calculation of Part D enrollees' out-of-pocket costs in determining when the catastrophic threshold would be reached; the Medicare covered portion would not be included in this calculation. *CBO estimates that changes made by the Reconciliation bill to Sections 3301 and 3315 of PPACA would increase costs by $24.8 billion over 10 years—from a score of $17.8 billion over 10 years for PPACA alone to $42.6 billion for PPACA and the Reconciliation bill combined.*[18]

[17] Part D premiums are not included in the calculation of a beneficiary's out-of-pocket costs.

[18] In a preliminary analysis, CBO estimated that the coverage gap provisions in the PPACA and the Reconciliation bill combined would lead to an average increase in premiums for Part D beneficiaries of about 4% in 2011, rising to about 9% in 2019—an increase of 1% in 2011 and 6% in 2019 from PPACA alone. The increase in premiums is attributed to the increased value of the drug benefit (premiums represent a percentage of total benefit spending). See "Comparison of Projected Medicare Part D Premiums Under Current Law and Under Reconciliation Legislation Combined with H.R. 3590 as Passed by the Senate," March 19, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11355/Comparison.pdf.

Changes to Address Fraud and Abuse

In an effort to further reduce Medicare fraud, waste, and abuse, the Reconciliation bill, as modified by the March 20, 2010, manager's amendment, adds two new provisions related to community mental health centers (Sec. 1301) and Medicare's claims review processes (Sec. 1302), and modifies two other provisions included in PPACA.

Under current law, community mental health centers (CMHCs) must meet certain requirements in order to receive payment under Medicare. For example, CMHCs must demonstrate that they can provide the core mental health services described in the Public Health Service Act and that they are licensed in the state in which they are operating. Section 1301 of the Reconciliation bill would require that a CMHC also demonstrate that it provides at least 40% of its service to individuals not eligible for Medicare. Section 1301 would also restrict Medicare reimbursement for mental health services delivered in an individual's home or in an inpatient or residential setting.

To protect the Medicare program from improper payments and fraudulent billing, Medicare contractors have the authority to review a provider's claims prior to payment. This is referred to as prepayment medical review. Under Medicare statute, contractors can only conduct prepayment review of a provider's claims under certain circumstances: (1) to develop a claims payment error rate and (2) only in instances where there is a likelihood of a sustained or high level of improper billing. Section 1302 of the Reconciliation bill would repeal these statutory limitations on prepayment review.

Activities to fight health care fraud, waste, and abuse are funded by the Health Care Fraud and Abuse Control (HCFAC) account. The total mandatory and discretionary funding level for HCFAC for FY2010 is approximately $1.5 billion. The PPACA appropriates an additional $10 million in mandatory funding for HCFAC for fiscal years 2011 through 2020. Section 1303[19] of the Reconciliation bill would appropriate an additional $250 million to HCFAC over fiscal years 2011 through 2016. The annual amount of the appropriation would begin at $95 million in FY2011 and decrease to $20 million by FY2015 and FY2016.

Lastly, PPACA includes a provision that provides the Secretary with the authority to impose enhanced screening and oversight measures on providers enrolling and re-enrolling in Medicare. Sec. 1304 of the Reconciliation bill would require the Secretary to withhold payment to DME suppliers for 90 days in instances when the Secretary determines that there is a significant risk of fraud.

CBO estimates that combined changes made by these provisions would lead to an additional savings of $0.6 billion over 10 years (combined Sections 6402 of PPACA and 1301-1304 of the Reconciliation bill)—from -$3.2 billion over 10 years for PPACA to -$3.8 billion for the combined bills.

[19] Section 1303 of the Reconciliation bill as introduced on March 18, 2010, which pertained to the disclosure of certain tax return information related to Medicare providers and suppliers by the Treasury to HHS, was removed by the March 20, 2010, manager's amendment. Prior Sections 1304 and 1305 were renumbered as 1303 and 1304.

Changes to Medicare Taxes[20]

Both PPACA and the Reconciliation bill include additional hospital insurance taxes on high-income taxpayers.

Medicare Payroll Tax

Under current law, employers and employees each pay a payroll tax of 1.45% to finance Medicare Part A. PPACA imposes an additional payroll tax of 0.9% on high-income workers with wages over $200,000 for single filers and $250,000 for joint filers effective for taxable years after December 31, 2012. The additional tax applies only to wages above these thresholds. For these workers, the payroll tax will increase to a total of 2.35% for wage income over the thresholds noted above. These additional revenues will go to the Medicare Hospital Insurance Trust Fund (often called Part A). The Reconciliation bill (Sec. 1402) would amend this to clarify that married taxpayers filing separately are subject to a $125,000 threshold. *According to the Joint Committee on Taxation, the score for the revenue provisions under PPACA would not be changed by the Reconciliation bill and would still be expected to raise $86.8 billion over a 10-year period.*

Unearned Income Medicare Contribution

The Reconciliation bill (Sec. 1402) would also impose an additional tax on net investment income. The Reconciliation bill defines net investment income to be interest, dividends, annuities, royalties, rents and taxable net capital gains. It excludes distributions from a qualified annuity from a pension plan.[21] Households with modified adjusted gross income under these thresholds would not be subject to the investment income tax. Specifically, effective for taxable years after December 31, 2012, the bill would impose a tax equal to 3.8% of the *lesser* of:

- Net investment income for such taxable year; or
- The excess of modified adjusted gross income (MAGI)[22] over $250,000 for joint filers ($125,000 for married filing separately and $200,000 for all other returns).

This tax is also applicable to income from estates and trusts. The active income from trade for self-employed and S-corporations would not be subject to the tax.[23] For these entities, the tax would apply only to passive income and trade income related to commodity trading. There is also a special provision for the application of the tax to S. Corporations that sell their businesses. *According to JCT, the investment income provision in the Reconciliation bill would raise an additional $123.4 billion in revenues over a 10-year period.*

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[20] For information on provisions related to annual fees on pharmaceutical companies and medical device manufacturers, and employer deductions related to the Medicare Part D retiree prescription drug subsidy, CRS Report R41128, *Health-Related Revenue Provisions: Changes Made by H.R. 4872, the Health Care and Education Reconciliation Act of 2010*, by (name redacted)

[21] As defined in the Internal Revenue Code (IRC) Sec. 401(a), 403(a), 403(b), 408, 408A, or 457(b).

[22] Modified adjusted gross income is defined as adjusted gross income increased by the excess of foreign earned income (defined in IRC Sec. 911(a)(1)) over the amount of any deductions or exclusions disallowed under IRC Sec. 911(d)(6) when determining foreign earned income.

[23] Corporations may elect S-corporation status if they meet a number of Internal Revenue Code requirements. Among other things, they cannot have more than 100 shareholders or more than one class of stock. S-corporations are tax-reporting rather than tax-paying entities, in contrast to C-corporations, which are subject to the corporate income tax.

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