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Modified Health & Education Reconciliation Bill

This Fact Sheet deals with the Senate amendments to HR 4872, the Health Care and Education Reconciliation Act, which the House is expected to take up later today, Thursday, March 25. The Senate passed the bill earlier today by a vote of 56 to 43, after removing two provisions through points of order.

The measure makes several changes to the recently enacted health care overhaul law (PL 111-148) by increasing federal subsidies in the law to help low- and moderate-income families purchase insurance through the health insurance exchanges that will take effect in 2014; phasing out the coverage gap or "doughnut hole" in the Medicare Part D prescription drug program; and adjusting federal matching funds that would be provided to states to cover the law's expansion of Medicaid eligibility. The bill also modifies the law's tax provisions by delaying and reducing the reach of the new excise tax on high-cost health plans, increasing the Medicare payroll tax on high-income taxpayers and making investment income subject to it, and adjusting industry fees and taxes.

The bill also terminates the federal government's ability to make or insure loans through the Federal Family Education Loan program, which would essentially make the government the sole originator of student loans and reduce mandatory spending by \$61 billion. Of those savings, \$42 billion would be spent on education programs, including an increase in the maximum Pell grant. In the Senate, budgetary points of order were raised against two provisions relating to the administration of Pell grants, which were then removed from the bill. Because of those changes, the House must act again on the bill in order to complete action and send it to the president.

Contents

I. Background & Summary	2
II. Health Care Provisions	10
III. Education Provisions	21
IV. Revenue Provisions	26

Section I

Background & Summary

After more than a year of debate on whether and how to change the domestic health insurance system, last Sunday, the House voted 219 to 212 to clear the Senate-passed health care overhaul bill for the president. The measure requires most individuals to obtain health insurance, creates state-run "exchanges" through which those without access to affordable insurance could purchase coverage, offers subsidies to low-income and moderate-income families to purchase coverage, creates penalties for employers with workers who receive federal subsidies to purchase insurance in the exchanges, and places new requirements on health insurance plans. It also expands eligibility for Medicaid to those with incomes of up to 133% of the federal poverty level. On Tuesday, President Obama signed the bill into law (PL 111-148). (For a description of the measure cleared by the House, see House Action Reports Fact Sheet No. 111-24, March 19.)

The new health care overhaul law, however, contains a number of controversial provisions, including a provision that extends indefinitely full federal funding to expand Medicaid coverage in Nebraska. The level of federal subsidies for lower-income households that purchase insurance in the new exchanges provided by the law is less than many members wanted, and the threshold at which the new tax on high-cost health care plans will kick in was also viewed by many as too low. Rather than negotiating a final version in a conference committee or taking a "ping pong" approach, both of which would have required a 60 votes to pass in the Senate, Democratic leaders decided to consider and pass a separate budget reconciliation measure to make changes to the outstanding points of controversy. In the Senate, budget reconciliation procedures block filibusters, limit the allowable amendments, and allow a reconciliation measure to be passed in the Senate by a simple majority. The process was intended as a budget-control tool, but it also has been used to advance other policies, such as tax cuts or increased federal spending. To date, 19 laws have been enacted using the reconciliation process.

On Sunday, directly after voting to clear the health care overhaul measure for the president, the House voted 220 to 211 to pass the reconciliation bill (HR 4872), thus sending it to the Senate. (See House Action Reports Fact Sheet No. 111-25, March 19 and Floor Summary No. 111-21, March 22.)

Changes by the Senate

On Tuesday, the Senate began debate on HR 4872, which faced staunch opposition from all Republican senators, who pledged to slow or block its process with procedural

tactics. Over the course of debate, the Senate considered and defeated dozens of Republican amendments to the bill during the course of a "vote-a-rama" that spilled over two days. Republican senators were, however, successful in raising a budgetary point of order relating to two education provision in the bill.

The "Byrd rule," named for its author Sen. Robert C. Byrd, D-W.Va., prohibits the inclusion of provisions considered "extraneous" to the core purpose of a reconciliation measure. Among other provisions, the Byrd rule specifically prohibits provisions that do not have any budgetary impact — i.e., those that do not result in a net change in outlays or revenue.

Earlier today during Senate consideration of the reconciliation measure, Sen. Judd Gregg, R-N.H., raised budgetary points of order against two provisions related to Pell grants, arguing that they violated the Byrd rule because they did not have any budgetary impact. The two provisions contained authorizing language related to how the Education Department administers Pell grants. Therefore, these provisions were eliminated from the measure. The Senate then passed the bill, as amended, by a vote of 56 to 43, and sent it back to the House.

Summary of Senate Amendments to HR 4872

Following is a summary of the bill as passed by the Senate; House passage would clear the measure for the president.

The Senate amendments to the bill make a number of changes to the recently enacted health care overhaul law (PL 111-148; see House Action Reports Fact Sheet No. 111-24, March 19, 2010). It increases federal subsidies to help low- and moderate-income families purchase insurance through the new health insurance exchanges created by the new law; phases out the coverage gap for Medicare prescription drug beneficiaries; adjusts federal matching funds for Medicaid to make them more equitable among all states; and eliminates language that provides 100% federal funding for new Medicaid beneficiaries in Nebraska for an unlimited amount of time.

The measure also modifies revenue-raising provisions in the new health care overhaul law. Specifically, it delays and reduces the impact of a new excise tax on high-cost health care plans; increases a Medicare payroll tax on high-income earners and applies that increased tax to investment income; modifies and increases new fees and taxes on health care-related industries; and includes a new revenue provision designed to prevent improper use of a biofuels tax credit.

The measure terminates the authority of the federal government to make or insure any additional loans in the Federal Family Education Loan programs after June 30, which would shift all further federal student lending to the Direct Loan program. The bill

dedicates some of the savings from this change to education programs, including an increase in the maximum Pell grant and additional funding for minority-serving institutions.

Health Care Provisions

This bill makes several changes to provisions in the new health overhaul law that are intended to expand access to health insurance coverage. Currently, an estimated 50 million Americans do not have health insurance. According to the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), the combined effects of this measure and the new health care overhaul law would result in a net decline of 32 million in the number of uninsured people.

CBO and JCT estimate that if Congress enacts this bill, in combination with the new health care overhaul law, the gross cost of expanding health insurance coverage would be \$938 billion over the period of FY 2010 through FY 2019 — including an estimated \$434 billion for Medicaid and CHIP outlays, \$464 billion for spending related to subsidies to allow lower-income households to purchase coverage through the new health insurance exchanges, and \$40 billion for small employer tax credits.

The measure does the following:

- **Individual Mandate** — Changes the tax penalty against those individuals or families who are required to obtain health insurance under the individual mandate in the new health care overhaul law, but do not do so.
- **Employer Penalties** — Changes the formula used to calculate penalties for employers that have employees who use subsidies to obtain health insurance through the new exchanges.
- **Premium Tax Credits** — Alters the formula used to calculate premium tax credits that would be available for households with annual incomes of between 100% and 400% of the federal poverty level to purchase health insurance through the new exchanges created by the health care overhaul law. It also limits the amount that certain households would have to contribute to their health insurance premiums.

- **Medicare Advantage** — Freezes Medicare Advantage (MA) payments in 2011, reformulates payments according to local costs in future years, and limits the amount that MA plans could spend on administrative expenses to 15%.
- **Prescription Drugs** — Provides a one-time \$250 rebate for Medicare Part D prescription drug beneficiaries in the coverage gap, or "doughnut hole," and phases it out over 10 years.
- **Funding for Medicaid Expansions** — Eliminates a provision in the new health care overhaul law that would provide 100% federal funding to cover new costs in Nebraska resulting from the expansion of Medicaid to all individuals up to 133% of the poverty line. It also revises the formula for providing funding to states.
- **Hospital Self-Referrals** — Delays implementation of new rules restricting the growth of physician-owned hospitals until Dec. 31, 2010, compared to Aug. 1, 2010, in the new health care law.
- **Insurance Regulations** — Delays the implementation, until six months after enactment, of several new insurance regulations, including requirements that bar insurers from rescinding coverage without evidence of fraud and that prohibit insurers from setting lifetime limits on the amount of health care covered.

Education Provisions

The measure shifts all new federal student lending to the Direct Loan program, beginning in July 2010, effectively ending the Federal Family Education Loans program. Under the bill, private lenders would be allowed to continue servicing student loans. Under a competitive bidding process, the Education Department would select lenders based on certain criteria.

As passed by the Senate, the bill does not include the following two provisions, which were struck by budgetary points of order offered by Sen. Judd Gregg, R-N.H.:

- A provision that would have authorized the Education Department to provide additional mandatory spending in FY 2010 and subsequent fiscal years, to cover the increased federal Pell grant amounts under the bill. The underlying bill, however, appropriates additional Pell grant funds and indexes funding for the grants to the Consumer Price Index starting in 2013.
- A provision that would have eliminated a requirement in current law that the Education Department reduce the funding available for Pell grants across-the-board if funding in a given year is insufficient, to provide the maximum grant level specified by law. The underlying bill essentially eliminates this requirement by stipulating that a Pell grant awarded in a given year could not be smaller than the grant awarded in a previous year, so striking this provision is not expected to have any impact on the legislation.

CBO estimates that the changes to the federal student loan program would produce savings of \$61 billion over 10 years. The measure directs that \$10 billion of those savings toward deficit reduction, and \$9 billion to offset the costs of the health care overhaul law.

The remaining \$42 billion would be spent on education programs, including an increase in the maximum Pell grant from \$5,550 in 2010 to \$5,975 in 2017. It also provides \$2.6 billion through FY 2019 for minority-serving institutions, \$500 million annually in FY 2010 through FY 2014 for community college programs, and \$750 million for a college access programs. It also modifies the terms of a student loan repayment program.

Revenue Provisions

The bill modifies several health care-related revenue provisions in the recently enacted health care overhaul law, and includes three new revenue provisions.

JCT estimates that enacting the revenue provisions in this bill, in combination with the new health care overhaul law, would result in a net increase in revenue of \$437.8

billion over the period of FY 2010 through FY 2019. (In contrast, the new health care overhaul law is estimated to result in a net increase in revenue of \$398.8 over that time period.)

The measure does the following:

- **Tax on High-Cost Plans** — Scales back a provision in the new health care overhaul law that imposes an excise tax on high-cost health plans. It delays the tax from taking effect until 2018, rather than 2013. It also increases the threshold at which the tax would apply to \$10,200 for individual health coverage and \$27,500 for family coverage. As modified by this bill, the tax on high-cost plans would raise \$32 billion over 10 years, much less than the estimated \$148.9 billion if the new law is not modified.
- **Medicare Payroll Tax** — Increases a Medicare payroll tax for high-income households, and applies the increased tax to investment income. It levies a 3.8% tax either on earned income that exceeds \$200,000 per year for an individual or \$250,000 for a couple, or on the net investment income that exceeds those annual thresholds, whichever is less. JCT estimates the modified version would raise \$210.2 billion over 10 years.
- **FSA Limit** — Delays the onset of a \$2,500 annual limit on flexible spending accounts (FSA) to 2013, rather than 2011, as under the new health care overhaul law.
- **Medical Device Tax** — Creates a 2.3% tax on the sale of certain medical devices, and exempts from this tax medical devices that are commonly purchased by the public at retail outlets. The tax would replace the industry-wide flat fee under the new health care overhaul law.
- **Other Industry Fees** — Delays and increases fees for the health insurance industry and pharmaceutical manufacturers created by the new health care

overhaul law.

- **Biofuel Credit** — Stipulates new requirements for fuels to qualify for a biofuel tax credit, which is intended to ensure that the credit is not improperly claimed. The new health care overhaul law did not include a similar provision.
- **Economic Substance Doctrine** — Codifies a judicial doctrine that is intended to allow more efficient prosecution of tax shelters. The new health care overhaul law did not include a similar provision.

Cost Estimate

CBO and JCT estimate if Congress enacts this bill, in combination with the new health care overhaul law, then the gross cost of expanding health insurance would be \$938 billion over the period of FY 2010 through FY 2019. After taking into account offsets, including taxes, penalties, and fees, CBO and JCT estimate that enacting this bill in combination with the new health care overhaul law would result in a net reduction in the deficit of \$138 billion over the period of FY 2010 through FY 2019.

In comparison, CBO and JCT estimate that under the new health care overhaul law (PL 111-148), the gross cost of expanding health insurance would be \$875 billion over the period of FY 2010 through FY 2019. When offsets under that law are taken into account, it is estimated to result in a net deficit reduction of \$118 billion over that time period.

CBO does not normally provide cost estimates beyond a 10-year window, however, because of member requests CBO developed a long-term, "rough" estimate for the period of FY 2020 through FY 2029 based on federal deficits as a share of gross domestic product (GDP). CBO estimates that if Congress enacts this bill in combination with the new health care overhaul law, federal deficits will fall over the period of FY 2020 through FY 2029 in a "broad range" of about one-half of one percent of GDP.

References

The House passed its version of the bill on March 21 by a vote of 220 to 211 (see House Action Reports Fact Sheet No. 111-24, Fact Sheet No. 111-25, and Floor Summary No. 111-21).

The Senate amended the bill and passed it by a vote of 56 to 43 on March 25.

See CQ Weekly, pp. 628, 568, 567, 240, 236 & 46. See 2009 CQ Weekly, pp. 2945, 2944, 2884, 2772, 2698, 2662, 2650, 2592, 1971, 1940, 1848, 772, 524 & 114.

Section II

Health Care Provisions

This section describes the provisions of the Senate amendments to HR 4872, the Health Care and Education Reconciliation Act, that modify provisions included in the health overhaul law (PL 111-148), except for those provisions dealing with revenue, which are covered in Section IV of this Fact Sheet.

None of the provisions described in this section were modified by the Senate during that chamber's consideration of the measure; therefore, this section describes the provisions as passed by the House on March 21.

Among other things, the measure increases subsidies that would be provided to low- and moderate-income households to purchase insurance coverage through the new insurance exchanges created by the health care overhaul law; increases penalties levied on employers that do not offer health benefits; phases out the current coverage gap in the Medicare prescription drug benefit; and eliminates a controversial provision that would have provided Nebraska with 100% federal funding for newly eligible Medicaid enrollees for an unlimited period of time.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that if Congress enacts this measure, combined with the recently enacted health overhaul law (PL 111-148), the gross cost of the expansion of health care coverage would be \$938 billion over the period of FY 2010 through FY 2019. Taking the offsets into account, the enactment of the provisions designed to expand health care coverage would reduce the deficit by a net \$124 billion over that time period. (Education-related provisions would reduce the deficit by an additional \$19 billion over that time. See Section III of this Fact Sheet for a description of education-related provisions.)

Currently, there are an estimated 50 million U.S. residents who lack health insurance. CBO estimates that if Congress enacts this reconciliation bill, in combination with the health care overhaul law, the number of residents without health insurance would decline by 32 million between 2010 and 2019. By 2019, CBO estimates that 24 million people would be enrolled in the new exchanges, and 16 million additional people would be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). A net 4 million people would lose employer-sponsored insurance, according to CBO.

Individual Mandate

The bill changes the tax penalty that would be required for individuals or families who are required to obtain health insurance under the individual mandate created by the health care overhaul law, but who do not do so.

First, it phases-in a flat penalty tax on households of \$695 per household member, per year, by 2016. (The new health care overhaul law would impose a flat penalty of \$750 per household member per year.)

Second, it increases the maximum penalty to 2.5% of household income, compared to 2% of household income in the health care law.

In a preliminary cost estimate, CBO and JCT estimate that these penalties, as created by the recently enacted health care law and modified by this bill, would generate \$17 billion over the period of FY 2010 through FY 2019.

Employer Requirements

The measure changes the formula in the health care law (PL 111-148) that would be used to calculate penalties for employers who have employees who obtain subsidies to obtain health insurance through the new exchanges.

Employers Who Offer Coverage

Under the health care overhaul law, employers with more than 50 employees who offer health benefits would face a penalty of either \$3,000 for each employee (full-time or part-time) who receives a subsidy, or \$750 per full-time employee, whichever would be less.

To calculate that fine, the reconciliation bill subtracts 30 employees from the actual number of people employed at a firm. For instance, a firm with 51 full-time employees in which any employee receives subsidies, would pay a fine of \$750 for 21, rather than 51, full-time employees.

Employers Who Do Not Offer Coverage

For employers who do not offer health insurance to employees, the health care overhaul law stipulates that for each full-time employee who receives a subsidy to purchase insurance through an exchange, the employer would face a fine of \$750 per employee.

The reconciliation bill increases the penalty for employers who do not offer health insurance to employees to \$2,000 for each full-time employee who receives a subsidy to purchase insurance through an exchange.

Eliminate Penalty for Waiting Period

In addition, the bill repeals a penalty included in the health care overhaul law for employers who require a waiting period for employees to enroll in health care coverage. (The law imposes a penalty of \$400 for each employee who has a 30-to-60 day waiting period, or \$600 for any employee who has a 61-to-90 day waiting period.)

Cost Estimate

CBO and JCT estimate that the employer penalties, as created by the recently enacted health care overhaul law and modified by this bill, would increase revenue by \$52 billion over the period of FY 2010 through FY 2019. CBO estimated that the health care overhaul law would increase revenue by \$27 billion over that same time period.

Assistance for Low- and Moderate-Income Households

Premium Tax Credits

The bill alters the formula in the recently enacted health care overhaul law to calculate premium tax credits that would be available for households with annual incomes of between 100% and 400% of the federal poverty level to purchase health insurance through the new exchanges that will be created in 2014. Currently, this income range would cover annual incomes of between \$22,050 and \$88,200 for a family of four.

The measure limits the amount that certain households would have to contribute to their health insurance premiums. Within each income bracket, the bill stipulates that premium tax credits would be determined on a sliding scale. The credit would limit the premiums families would have to pay to a percentage of their income, as follows:

- Households with incomes of 133% up to 150% of the federal poverty level would pay between 3% and 4% of their income for premiums;
- those between 150% up to 200% of the federal poverty level would pay between 4% and 6.3% of their income;
- those between 200% up to 250% of the federal poverty level would pay between 6.3% and 8.05% of their income;
- those between 250% up to 300% of the federal poverty level would pay between 8.05% and 9.5% of

their income;

- and those with income of 300% up to 400% of the federal poverty level would pay 9.5% of their income for premiums.

The bill stipulates that, starting in 2015, the premium tax credits would have to be adjusted to reflect year-to-year premium growth in the health plans.

The bill also modifies the definition of modified gross income that would be used when determining eligibility for subsidies to exclude employer-sponsored health care coverage for children up to age 26 from modified gross income.

According to CBO and JCT, if this reconciliation measure is enacted, the average federal subsidy in 2015 would be \$5,200 per household.

Limits on Out-of-Pocket Costs

In addition, the bill alters the percentage of actuarial benefits of a health care plan that lower-income households would be required to pay out-of-pocket when purchasing health care coverage through the new exchanges. It stipulates that households with incomes between 100% and 150% of the federal poverty level would have to pay no more than 6% of the plan's costs from out-of-pocket funds. Households with incomes between 150% and 200% of the federal poverty level would have to pay no more than 13% of a plan's costs out-of-pocket. Households with incomes between 200% and 250% of the federal poverty level would have to pay no more than 27% of the plan's costs out-of-pocket, and those with incomes between 250% and 400% of federal poverty level would have to pay no more than 30% of the plan's cost out-of-pocket.

Cost Estimate

CBO and JCT estimate that this provision would increase mandatory spending by \$15 billion over the period of FY 2010 through FY 2019, in comparison to the health care overhaul law. In combination with the health care law, the premium tax credits, cost-sharing subsidies, and related costs would increase mandatory spending by \$464 billion over that time period.

Health Insurance Reform Implementation Fund

The bill also includes a provision that appropriates \$1 billion to the Health and Human Services (HHS) Department for the administrative costs of implementing the new health care overhaul law (PL 111-148), and amendments to the law made by this measure.

Medicare Provisions

Medicare Advantage Payments

Medicare Part C — better known as Medicare Advantage (MA) — is an alternative to traditional Medicare under which Medicare-eligible individuals are insured by private firms, rather than the federal government. The program was designated MA under the 2003 prescription drug law (PL 108-173) which replaced the "Medicare+Choice" program with MA. The private plans receive a per-person amount to cover certain benefits. Premiums for Medicare B coverage are paid to Medicare, but additional amounts may be paid to the MA provider.

The bill freezes MA payments in 2011 and then re-formulates payments according to local costs. Under the new formula, which would be phased-in, MA payments would be allocated based on geographic variability of Medicare spending. MA payments would be 95% of traditional fee-for-service Medicare payments in areas that are in the top quartile of Medicare spending. MA payments would be 100% of traditional fee-for-service payments in the second-highest quartile of spending. MA payments would be 107.5% of fee-for-service payments in areas in the third-highest quartile of spending. MA payments would be 115% of fee-for-service payments for areas in the lowest quartile of spending.

In addition, the measure limits the amount that MA plans could spend on administrative costs to 15%. If a plan spent more than 15% of the amount collected from premiums on administrative costs, it would have to pay HHS a fine that would be equal to the amount of funds spent on administrative costs that exceeded 15%.

The bill changes the way that the Centers for Medicare and Medicaid Services (CMS) would adjust payments to MA plans. Under current law, CMS adjusts the amounts based on the health status of the beneficiaries covered, and to reflect the differences in treatments and coding between MA plans and traditional Medicare plans. The measure specifies certain proportions that would be used for the adjustments so that they would be phased-in over several years.

According to CBO and JCT, if Congress enacts this measure, the changes to MA payments would reduce mandatory spending by \$17.5 billion over the period of FY 2010 through FY 2019, compared to the recently enacted health overhaul law. In combination with the new law, these changes would reduce mandatory spending by \$135.6 billion over that time.

Prescription Drug 'Doughnut Hole'

Under the 2003 law that created Part D, after a beneficiary meets his or her deductible for the year, a beneficiary will have 75% of his or her drug costs covered by

the government up until a set dollar amount, which was initially set at \$2,250, but has increased to \$2,830 in 2010 as a result of inflationary increases permitted beginning in 2007. After that dollar amount has been reached, the beneficiary is responsible for 100% of the cost of prescriptions up to another dollar amount, known as the catastrophic threshold. When beneficiaries are responsible for 100% of costs, they are said to be in the coverage gap, or the "doughnut hole," which is \$6,440 in 2010. The federal government is responsible for 95% of the costs above the upper catastrophic limit for the rest of the year.

The measure provides a one-time \$250 rebate for beneficiaries who fall into the "doughnut hole" in 2010. It phases out the "doughnut hole" over 10 years. Starting in 2011, the measure creates a discount of 50% on brand-name drugs for beneficiaries who fall into the "doughnut hole," and this discount would increase to 75% by 2020, with the government paying the rest of the cost of the drugs.

The measure also makes changes to how the catastrophic threshold is calculated. Currently, the catastrophic threshold is based on the average aggregate costs for all Medicare Part D beneficiaries — meaning that the more that drug prices in Medicare plans increase, the higher the catastrophic threshold. The bill specifies that the annual catastrophic threshold for Medicare Part D beneficiaries would grow more slowly than the average costs for drugs for all beneficiaries in Part D in 2011 through 2019. Then, in 2020, the growth rate would revert back to the way it is currently calculated.

CBO and JCT estimate that the changes to the "doughnut hole" would increase mandatory spending by \$24.8 billion over the period of FY 2010 through FY 2019, compared to the recently enacted health care overhaul law. In combination with the effects of the new law, this provision would increase mandatory spending by \$42.6 billion over that time period.

'Market Basket Updates'

The measure makes several changes to the market basket updates used to determine the reimbursement for certain services under Medicare Part A, which covers hospital services. Generally, market baskets are used to adjust payments each year based on projected changes in indexes that are used to measure how much more or less it would cost to buy the same goods and services.

The measure modifies the "productivity adjustments" — adjustments based on gains in productivity — that the health care overhaul law would incorporate into several market baskets used under Part A that do not currently incorporate such provisions. The adjustments would be phased-in during different years for different types of providers, and would affect inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospitals. The formula in the measure is

expected to generate additional cost savings, compared to the health care overhaul law, while affecting fewer facilities.

CBO and JCT project that enacting this provision would result in a reduction of mandatory spending of \$9.8 billion over the period of FY 2010 through FY 2019, compared to the recently enacted health care law. In combination with the new law, the provision would reduce mandatory spending by an estimated \$156.6 billion over that time.

Medicare DSH Payments

Medicare disproportionate share hospital (DSH) payments are provided to hospitals that treat a disproportionate share of low-income patients. The bill requires that DSH payments be reduced by 75% starting in FY 2014, and then increases payments based on the percentage of the population that is uninsured and care provided to uninsured patients. The measure provides for a more generous increase in DSH payments in FY 2015 through FY 2019 than the health care overhaul law. (In comparison, the overhaul law reduces DSH payments by 75% starting in FY 2012, and then increases payments based on the percentage of the population that is uninsured and the amount of care provided to uninsured patients.)

CBO and JCT estimate that this provision would increase mandatory spending by \$3 billion over the period of FY 2010 through FY 2019, in comparison to the recently enacted health care overhaul law. In combination with the new law, the provision would reduce mandatory spending on DSH payments by \$22.1 billion through FY 2019.

Hospital Payments

In addition, the bill sets aside \$400 million from the Federal Hospital Trust Fund in FY 2011 and FY 2012 for additional Medicare payments to hospitals that are located in counties that are in the lowest quartile of per-capita Medicare spending for Part A and Part B (i.e., hospital services and physician services, respectively).

Medicaid

Federal Matching Funds for States

Currently, states consider parents and childless adults differently in terms of Medicaid eligibility. All states provide Medicaid to eligible parents, and state income eligibility for parents in traditional Medicaid ranges from 24% of the federal poverty level in Alabama to 215% of the federal poverty level in Minnesota. Eighteen states provide Medicaid coverage to childless adults, and an additional five states and the District of Columbia provide state-funded coverage to childless adults.

The health care overhaul law (PL 111-148) expands Medicaid eligibility to all individuals with incomes of up to 133% of the federal poverty level, which is currently \$14,404 for an individual or \$29,327 for a family of four.

This bill specifies that in all states, the federal government would cover 100% of the cost of coverage to newly eligible people — including both parents and childless adults — from 2014 through 2016. In 2017, federal matching funds for all states would cover 95% of the costs for the newly eligible people, and the rate would be 94% in 2018, 93% in 2019, and 90% in 2020 and later years. (In contrast, the recently enacted health care overhaul law includes a formula that would provide certain federal matching funds to states that did not previously cover parents or childless adults with incomes of at least 100% of the federal poverty level, and a different formula that provided less funding for states that did previously cover parents or adults at that income level.)

The measure also reduces the state portion of the costs of covering childless adults for states that have previously provided such coverage to individuals at 100% of the federal poverty level or greater. This provision ensures that a state that previously provided coverage to childless adults who continue to be enrolled in Medicaid would receive the same federal funding as a state that did not previously provide such coverage.

The bill eliminates the provision in the health care overhaul law under which Nebraska would continue to receive 100% federal funding for newly eligible individuals for an unlimited time. It also eliminates the provision in the health care overhaul law that provides an increase for parents and childless adults who were previously enrolled in Medicaid in Massachusetts.

Medicaid DSH Payments

The measure requires a reduction in federal matching payments to states for Medicaid DSH payments, which are additional reimbursements for hospitals that serve a disproportionate share of low-income individuals. Specifically, the measure requires a reduction in DSH payments by \$14.1 billion over the period of FY 2014 through FY 2019.

The bill also specifies that Tennessee — which does not receive Medicaid DSH payments because of the way it has structured its Medicaid program — would receive \$47.2 million in payments in FY 2012 and \$53.1 million in FY 2013.

(Under the recently enacted health care overhaul law, states' DSH payments would be reduced by 50% in many cases, or by 25% for states that receive low DSH payments. These reductions would not take effect until a state's uninsured rate had decreased by 45%.)

Medicaid Funding for Territories

The bill provides additional federal Medicaid funding for the U.S. territories. It appropriates an increase of \$1 billion for federal matching payments for Medicaid programs in the five U.S. territories over the period of FY 2014 through FY 2019, which would be in addition to the amount provided by the health care overhaul law, and it specifies that \$925 million of that amount would go to Puerto Rico. It also increases the caps on federal funding in the territories.

CBO estimates that this provision would increase mandatory spending by \$2 billion over the period of FY 2010 through FY 2019, compared to the new health care overhaul law. In combination with provisions in the new law, it would increase mandatory spending by \$7.3 billion through FY 2019.

Other Provisions

Physician-Owned Hospitals

The recently enacted health care overhaul law places new restrictions on how physicians can refer patients to hospitals in which they have an investment interest. The provision is intended to close what supporters view as a loophole that creates potential conflicts of interest and potential impacts on patient safety and Medicare costs. The measure generally prohibits new physician-owned hospitals from receiving Medicare reimbursements. Specifically, it permits physician self-referrals to hospitals only if the hospitals meet the certain criteria.

(For more details about how the health overhaul law changes Medicare reimbursement rules for physician-owned hospitals, see Section IV of House Action Reports Fact Sheet No. 111-24, March 19).

This measure modifies the provision in the health care overhaul law to delay, until Dec. 31, 2010, the implementation of the new rules. It also creates an exception to the rules, through which physician-owned hospitals with a high proportion of Medicaid patients would be able to expand their capacity, but places limits on such expansion.

Insurance Regulations

The health care overhaul law includes a number of new regulations on health insurance companies. This measure delays — until six months after enactment, instead of immediately upon enactment — implementation of a provision stipulating that health insurers could rescind group or individual coverage only with clear and convincing evidence of fraud or intentional misrepresentation by an enrollee.

It also delays — until six months after enactment — a provision that requires insurance plans to allow parents to continue coverage for dependent children who would otherwise not have health insurance until a child reaches his or her 26th birthday, and a provision that prohibits insurers from setting lifetime limits on the dollar value of health care until six months after enactment. (In the recently enacted health care law, both of these provisions would have taken effect immediately.)

The bill bars health care plans from setting any annual limits on the dollar value of health care provided, effective six months after enactment. The health care overhaul law would implement this requirement starting in 2014, so this bill would accelerate the effective date.

Community Health Centers

The measure increases the amount appropriated for community health centers. It appropriates \$1 billion in FY 2011, \$1.2 billion in FY 2012, \$1.5 billion in FY 2013, \$2.2 billion in FY 2014, and \$3.6 billion in FY 2015.

(In comparison, the new health care law appropriates a total of \$7 billion over fiscal years 2011 through 2015.)

Fraud in Public Programs

The bill appropriates \$95 million in FY 2011, \$55 million in FY 2012, \$30 million in each of fiscal years 2013 and 2014, and \$20 million in each of fiscal years 2015 and 2016 for the Health Care Fraud and Abuse Control Fund, which would be used to combat fraud in Medicaid programs.

The measure requires that in cases where a durable medical equipment supplier is suspected of fraud, CMS would have to withhold payment from the supplier for 90 days while a review is conducted.

Section III

Education Provisions

This section deals with the provisions of the Senate amendments to HR 4872, the Health Care and Education Reconciliation Act, that make changes to the federal student loan program and provide funding for other education programs.

The measure shifts all new federal student lending to the Direct Loan Program, beginning July 1, 2010, effectively ending the Federal Family Education Loans (FFEL) program. Under the bill, private lenders would be allowed to continue servicing student loans. Under a competitive bidding process, the Education Department would select lenders based on how well they serve borrowers, educate them financially, and prevent loan defaults.

During Senate consideration, two provisions were struck by budgetary points of order. These provisions contained authorizing language with respect to the administration of Pell grants by the Education Department.

The Congressional Budget Office (CBO) estimates that the measure's changes to the federal student loan program would produce savings of \$61 billion. Of that, the bill directs \$10 billion toward deficit reduction and \$9 billion to offset costs of the health care overhaul. The remaining \$42 billion in savings would be used for new education spending.

The bill increases the maximum annual Pell Grant scholarship from \$5,550 in 2010 to \$5,975 in 2017, provides \$2.6 billion for minority-serving institutions, provides \$500 million annually from FY 2010 through FY 2014 for community colleges, and provides \$750 million for a college access program. The measure also modifies the terms of the income-based student loan repayment program.

Existing Programs & Changes from Previous House Bill

Created in 1965, the Federal Family Education Loan program provides federally guaranteed private student loans to students and their families. The Direct Loan program, established by the 1993 Student Loan Reform Act (PL 103-66) signed by President Bill Clinton, provides student loans from the federal government directly to borrowers.

The Perkins Loan Program provides federally subsidized low-interest loans to help low-income students finance the costs of postsecondary education. Stafford loans are federally guaranteed, fixed-rate loans for students attending school at least half-time.

Students are not required to make payments while enrolled in school. Both programs currently allow private lenders to issue student loans with the federal government, providing lenders with subsidies to reduce the interest rate on the loans, and the government guarantees repayment of the loans.

Last September, the House passed legislation (HR 3221; see House Action Reports Legislative Week of September 14, 2009) by a vote of 253 to 171 that would have ended student loan programs under which private lenders issue federally subsidized and guaranteed loans, and shifted these programs into the federal Direct Loan Program.

The reconciliation bill also shifts the private sector's role in the provision of student aid, but provides 45% less spending for education programs than the original House-passed bill. CBO estimated that the House's previous measure would have reduced federal spending on student loans by \$87 billion, of which \$77 billion was directed to spending on education programs. Since that bill passed, CBO reduced its estimate of the projected savings from ending the FFEL program, as more colleges and universities voluntarily enrolled in the federal lending program, and costs associated with higher student eligibility and enrollment rose.

The reconciliation measure provides less money for financial aid and community colleges than the previous measure, and it provides no new funding for early education. In addition, the reconciliation bill does not include the \$8.8 billion in the previous measure for the American Graduation Initiative, which was aimed at improving graduation rates and upgrading facilities at the nation's approximately 1,200 two-year colleges.

Termination of Private Lending Program

The bill terminates the authority to make or insure any additional loans in the Federal Family Education Loan and insurance programs after June 30, 2010, thus shifting all new federal student lending to the Direct Loan Program. As a result, the federal government would originate all student loans, while private lenders would still be permitted to continue servicing government-issued loans.

Increasing Pell Grants

The bill increases the maximum annual Pell Grant scholarship from \$5,550 in 2010, to \$5,975 in 2017.

The measure also makes future funding for Pell Grants mandatory and ties annual increases to changes in the Consumer Price Index. The mandatory component of the funding would be determined by inflating the previous year's total and subtracting the maximum award provided for in the appropriations law for the previous year, or \$4,860,

whichever is greater. Beginning in the 2018-2019 academic year, the maximum Pell award would remain at the 2017-2018 level.

The measure provides \$13.5 billion in mandatory appropriations for the federal Pell Grant program.

Provisions Struck During Senate Consideration

During Senate consideration, the following two provisions were eliminated from the bill because of budgetary points of order raised by Sen. Judd Gregg, R-N.H.:

- A provision that would have authorized the Education Department to provide additional mandatory spending in FY 2010 and subsequent fiscal years to cover the increased federal Pell grant amounts under the bill. The underlying bill, however, appropriates additional Pell grant funds and indexes funding for the grants to the Consumer Price Index starting in 2013.
- A provision that would have eliminated a requirement in current law that the Education Department reduce the funding available for Pell grants across-the-board if the funding in a given year is insufficient, to provide the maximum grant level specified by law. The underlying bill essentially eliminates this requirement by requiring that a Pell grant awarded in a given year could not be smaller than the grant awarded in a previous year, so striking this provision is not expected to have any impact on the legislation.

The provisions were ruled "extraneous" under the Byrd rule because they did not have any budgetary impact.

Student Loan Repayment Changes

The measure amends the Income-Based Repayment program to cap student loan payments for new borrowers after July 1, 2014, at 10% of adjusted income, rather than 15% percent. It also would forgive remaining balances after 20 years of repayment, rather than the 25 years currently allowed.

Loan Servicing

The measure directs the Education Department to award contracts for servicing federal direct loans to eligible nonprofit servicers. For the first 100,000 borrower loan accounts, the bill directs the Education Department to establish a separate pricing tier. The measure also directs the department to allocate the loan accounts of 100,000 borrowers to each eligible nonprofit servicer, and to reallocate, increase, reduce or terminate an eligible nonprofit servicer's allocation based on the performance of such servicer.

The bill appropriates mandatory funds for the administrative costs of servicing contracts with eligible nonprofit servicers, and it provides \$50 million in technical assistance to institutions of higher education participating in, or seeking to participate in, the direct lending program.

Finally, the measure appropriates \$25 million for each of fiscal years 2010 and 2011 for payments to loan servicers to retain jobs at locations in the United States where such servicers were operating on Jan. 1, 2010.

Minority-Serving Institutions

The bill provides \$2.6 billion through 2019 for programs at Historically Black Colleges and Universities and minority-serving institutions. The programs include those that help low-income students attain degrees in the fields of science, technology, engineering or mathematics.

Specifically, the measure provides \$100 million to Hispanic Serving Institutions, \$85 million to Historically Black Colleges and Universities, \$15 million to Predominantly Black Institutions, \$30 million to Tribal Colleges and Universities, \$15 million to Alaskan and Hawaiian Native Institutions, \$5 million to Asian American and Pacific Islander Institutions, and \$5 million to Native American non-tribal serving institutions.

Community Colleges

The bill appropriates \$500 million per year in fiscal years 2010 through 2014 for the Community College and Career Training Grant program for community colleges to develop and improve educational or career training programs.

The measure ensures that each state would receive at least 0.5 % of the total funds appropriated.

College Access Program

The measure provides \$750 million for the College Access Challenge Grant program. The program provides grants to states in order to help organizations provide services that increase the number of low-income students who are prepared to enter college and manage their student loans, through initiatives such as financial literacy and debt management skills.

Bank of North Dakota

The bill does not include a provision that would have allowed the Bank of North Dakota to continue to offer student loans. The bank is owned by the state of North Dakota and is the only state-owned bank in the country. This provision had come under criticism as a special perk, and on March 18, Sen. Kent Conrad, D-N.D., asked that the provision be removed.

Section IV

Revenue Provisions

This section describes the provisions of the Senate amendments to HR 4872, the Health Care and Education Reconciliation Act, that modify the revenue provisions included in the new health care overhaul law (PL 111-148).

These provisions were not modified by the Senate, and thus they are the same as those in the House-passed bill. The measure modifies a number of health care revenue provisions in the law, including delaying and reducing the impact of a tax on high-cost health care plans; applying an increased Medicare payroll tax to the investment income of high-income households; and delaying and modifying the way new fees would be levied on health insurers, drug makers and medical device makers. The measure includes two additional revenue provisions — a clarification of the applicability of a biofuel tax credit under current law, and a codification of a judicial doctrine that has been used to prosecute alleged tax shelters.

According to an estimate by the Joint Committee on Taxation (JCT), the combined effects of enacting this bill, along with the new health care overhaul law, would be a net increase in revenue of \$437.8 billion over the period of FY 2010 through FY 2019. In contrast, JCT estimates that the new health care law would result in a net increase in revenue of \$398.8 billion over that time period.

Tax on High-Cost Health Plans

The bill substantially scales back a provision in the recently enacted health care overhaul law (PL 111-148) that imposes an excise tax on high-cost health plans, referred to as Cadillac plans. It delays the effective date of the tax and increases the threshold at which the tax would apply. It delays the tax from taking effect until 2018, rather than in 2013, as the law requires. It increases the threshold at which the tax would apply to \$10,200 for individual coverage and \$27,500 for family coverage

(The new health care overhaul law institutes a 40% tax on the portion of employer-sponsored health insurance plans that exceed aggregate costs of greater than \$8,500 per year for individual coverage or \$23,500 per year for family coverage. After 2013, those amounts are set to increase according to inflation.)

JCT estimates that the provision included in the new health care overhaul law would increase revenue by \$148.9 billion over the period of FY 2010 through FY 2019, but as modified by this measure, the provision would generate \$32 billion over that same period.

Medicare Payroll Tax for Investment Income

The new health care overhaul law (PL 111-148) increases the Medicare hospital payroll tax to 2.35% of income, from the current 1.45% of incomes for any earned income that exceeds \$200,000 for an individual or \$250,000 for a couple, starting in 2013.

This bill expands that provision by increasing the tax and also applying a new Medicare payroll tax on investment income, a change that has been sought by the White House. The measure imposes a 3.8% tax on either a household's net investment income, or the amount of modified adjusted gross income that exceeds \$200,000 for an individual or \$250,000 for a couple, whichever is less. It also applies the increased tax not only to earned income, but also to investment income, including estate and trust income, dividends, interest, royalties or rents.

JCT estimates that, in combination with the new health care overhaul law, the increased Medicare payroll tax would increase revenue by \$210.2 billion over the period of FY 2010 through FY 2019. In contrast, the provision included in the health care overhaul law is estimated to increase revenue by \$86.8 billion over that time period.

Flexible Spending Account Limits

Flexible Spending Accounts (FSAs) are offered by employers and permit employees to deposit pre-tax amounts into an account to cover out-of-pocket payments for qualifying medical expenses such as prescription drug co-payments, co-payments for office visits and over-the-counter medicines. There is currently no limit to the amount that someone can deposit into an FSA, although employers may set up a cap, and most do.

The recently enacted health care overhaul law (PL 111-148) limits annual contributions to FSAs to \$2,500, starting in 2011.

This measure modifies that provision by delaying the new limit until 2013.

According to JCT, in combination with the new health care overhaul law, this measure would increase revenue by \$13 billion over the period of FY 2010 through FY 2019. In contrast, the health care overhaul law by itself is estimated to increase revenue by \$14 billion over that time period.

Industry Fees & Taxes

The measure modifies the new fees for health insurers, medical device manufacturers and pharmaceutical manufacturers created under the new health care overhaul law (PL 111-148).

JCT estimates that, in combination with the new health care overhaul law, the fees would generate a total of \$107.1 billion in revenue over the period of FY 2010 through FY 2019. Under the new health care overhaul law, in contrast, the fees would generate an estimated \$101 billion over that time period.

Fees for Health Insurers

The bill delays industry fees for health insurers until 2014, three years later than the 2011 effective date included in the new health care overhaul law. It also increases the annual flat fee that would be levied on the insurance industry to \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. In 2019, the fees would be adjusted by the same rate as the growth in health insurance premiums.

(In contrast, the health care overhaul law would impose fees of \$2 billion in 2011, \$4 billion in 2012, \$7 billion in 2013, \$9 billion in 2014 through 2016, and \$10 billion in 2017 and beyond. The law distributes the fees based on the net amount of premiums written, as well as insurers' market share.)

JCT estimates that the combined effects of the new health care overhaul law and this measure would generate \$60.1 billion over the period of FY 2010 through FY 2019. Under the new health law, the fees would generate \$59.6 billion over that period.

Taxes for Medical Device Makers

The bill creates a 2.3% tax on the sale of any taxable medical device by a manufacturer or importer of such a device, rather than imposing a flat fee on the industry, as contained in the recently enacted health care overhaul law (PL 111-148).

The bill specifies that the tax would not apply to eyeglasses, contact lenses, hearing aids, or any other medical device that is determined by FDA to be an item that "is generally purchased by the general public at retail for individual use."

Under the bill, the tax would take effect on 2013. The fee in the new health care overhaul law would take effect two years earlier, in 2011.

JCT estimates that in combination with the new health care overhaul law, this provision would increase revenue by \$20 billion over the period of FY 2010 through FY 2019. The provision included in the health care overhaul law is estimated to increase revenue by \$19.2 billion through FY 2019.

Fees for Pharmaceutical Manufacturers

The bill delays industry fees created by the health care overhaul law for pharmaceutical makers by one year, until 2011. It also increases the annual industry-wide fees that would be levied on brand-name drugs to \$2.5 billion in 2011, \$2.8 billion 2012 and 2013, \$3 billion in 2014 through 2016, \$4 billion 2017, \$4.1 billion in 2018, and \$2.8 billion in 2019 and later years.

(The health care overhaul law imposes a \$2.3 billion fee on the industry in 2010 and subsequent years and creates a formula for allocating fees across firms based on annual sales with certain exceptions for smaller firms.)

According to JCT, the combined effects of both this bill and the new health care overhaul law would be to increase revenue by \$27 billion over the period of FY 2010 through FY 2019. Under the current health care overhaul law, JCT estimates that the fees would generate revenue of \$22.2 billion over that time period.

Tax Treatment of Medicare Part D Subsidies

Certain employers can receive federal subsidies for Medicare Part D prescription drug benefits that they provide to retirees, and any such subsidy can be excluded from gross income and shielded from taxation. Current law also permits employers to claim a deduction for such expenses, even though they are subsidized by the government.

The health care overhaul law (PL 111-148) bars employers from claiming a deduction for subsidized expenses for providing drug benefits to retirees in these cases, starting in 2011. This measure delays implementation of this ban until 2013.

JCT estimates that this provision, in combination with the new health care overhaul law, would increase revenue by \$4.5 billion over the period of FY 2010 through FY 2019. The provision included in the health care overhaul law is estimated to increase revenue by \$5.4 billion through FY 2019, and the delay in the provision is expected to reduce revenue.

Change to Biofuel Tax Credit

The 2008 farm law (PL 110-246) created a \$1.01-per-gallon credit for the production of biofuels from cellulosic feedstocks, which was designed to encourage production of biofuels that are not derived from feedstocks. There are concerns that since its creation, some taxpayers have been trying to obtain the credit for non-processed fuels, including "black liquor," which is a byproduct from paper manufacturing.

The bill modifies the rules of the credit to preclude black liquor from eligibility and ensure that the tax credit could only be used for fuels that could be used in a car engine or

to heat buildings. Specifically, it excludes any fuel if more than 4% of the fuel, determined by weight, is a combination of water or sediment, or if the ash content of the fuel is more than 1% as determined by weight. The new rules would take effect for fuels sold or used on or after Jan. 1, 2010.

This provision was included in the House-passed health care overhaul bill (HR 3962), but was not included in the health care overhaul law (PL 111-148).

According to JCT, this provision would increase revenue by \$23.6 billion over the period of FY 2010 through FY 2019.

Codification of Economic Doctrine

The measure clarifies the application of the "economic substance doctrine," which is a judicial doctrine developed through several court cases which generally denies tax benefits from a transaction unless it has "economic substance," i.e., it results in a meaningful change in a taxpayer's economic condition, not just a tax benefit. The doctrine has been used by the IRS to go after tax shelters.

Similar provisions have been debated in the past by both the House and Senate, and the provision was included in the House-passed health care overhaul measure (HR 3962), but not in the new health care overhaul law (PL 111-148).

In the past, the IRS has not supported codifying the doctrine, arguing that it would best be used when it is appropriate. Others have opposed codifying it, arguing that it could complicate the tax code, or could be written in a manner that would be either too broad or not broad enough. According to JCT, this provision would increase revenue by \$4.5 billion through FY 2019.

Clarification of Doctrine

The bill stipulates that, in the case of any transaction to which the economic substance doctrine is relevant, that transaction would be treated as having economic substance only if the transaction changes a taxpayer's economic position in a meaningful way, apart from federal income tax effects, and the taxpayer has a substantial purpose for entering into such a transaction, apart from federal income tax effects.

The bill provides a special rule when taxpayers rely on profit potential, allowing the potential for profit to be taken into account only if the present value of the reasonably expected pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected. Under the bill, fees, other transactions, and foreign taxes would be taken into account as expenses when determining pre-tax profit. The bill treats any state or local tax effect that

is related to a federal income tax effect in the same manner as a federal tax effect, and stipulates that achieving a financial accounting benefit would not be taken into account as a purpose for entering into a transaction if the transaction results in a federal income tax benefit.

The bill defines "economic substance doctrine" as the common law doctrine under which certain tax benefits, with respect to a transaction, are not allowable if the transaction does not have economic substance or lacks a business purpose. In the case of an individual, the bill's definition would apply only to transactions that are entered into in connection with trade or business or an activity engaged in for the production of income. The measure states that the determination of whether the doctrine is relevant would be made in the same manner as if this provision had not been enacted. These changes would apply to transactions entered into after the date of enactment.

Penalties

The measure imposes a penalty when claimed tax benefits are disallowed because a transaction lacked economic substance or failed to meet the requirements of any similar rule of law. The penalty would generally be 20%, but the bill provides for an increase to 40% to the extent that the portion of the underpayment is attributable to one or more "nondisclosed non-economic substance transactions," i.e., any portion of a transaction with respect to which the relevant facts affecting the tax treatment are not adequately disclosed in a tax return or a statement attached to a tax return. The measure also provides a rule for the treatment of amended returns, generally barring an amendment or supplement from being taken into account if it is filed after the taxpayer is first contacted regarding the return, or another date specified by the Treasury Department, whichever occurs earlier.

Payment of Corporate Estimated Taxes

The bill adjusts the estimated corporate tax payments that corporations with at least \$1 billion in assets would be required to pay in 2014. These changes help make the measure comply with pay-as-you-go rules for the "windows" used to determine budgetary effects of legislation, and to ensure that the measure meets the deficit-reduction targets over five years that the bill must meet for reconciliation purposes. The provisions have no net impact through FY 2019. The bill increases by 15.75 percentage points the amount that would be due in July, August or September of 2014, and decreases the payments due in the following quarter by a corresponding amount. JCT estimates that this would shift \$8.1 billion in revenue from FY 2015 to FY 2014.