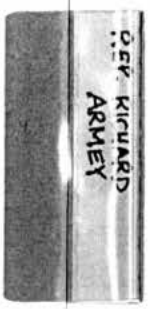
Sarah Bianchi
Box #4

- Background: Medicare Tax Credit
- Family Conference
- Family Safety Regulations
- Background: Food Safety
- Fraud and Abuse
- Genetics
- Genetic Discrimination
- GRIJALVA
- Heart Disease
- HCFA/Schools
- Home Care
- Home Care II
- Human Genome Project
- Hunger Relief Act
- Long Term Care Contacts
- Long Term Care
- Health Memoms
- L.T.C. Research
- Info-Health Names
- Admin: IBM

Background: Healthcare Tax Credit



Bill Summary & Status for the 106th Congress

Item 9 of 12

PREVIOUS BILL | NEXT BILL
PREVIOUS BILL:ALL | NEXT BILL:ALL
NEW SEARCH | HOME | HELP

H.R.2362
SPONSOR: **Rep Armey, Richard K.** (introduced 06/25/99)

Jump to: Titles, Status, Committees, Amendments, Cosponsors, Summary

TITLE(S):

- SHORT TITLE(S) AS INTRODUCED:
  Fair Care for the Uninsured Act of 1999

- OFFICIAL TITLE AS INTRODUCED:
  A bill to amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance, and to provide for a report on State health insurance safety-net program.

STATUS: Floor Actions

NONE

STATUS: Detailed Legislative Status

House Actions

Jun 25, 99:
Referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. Referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

STATUS: Congressional Record Page References

06/25/99 Introductory remarks on Measure (CR H4957, E1405-1406)

COMMITTEE(S):

- COMMITTEE(S) OF REFERRAL:
  House Ways and Means
  House Commerce

AMENDMENT(S):

NONE

COSPONSOR(S):

NONE

SUMMARY:

(AS INTRODUCED)

TABLE OF CONTENTS:

Digest will follow.

HR 2362 IH

106th CONGRESS

1st Session

H. R. 2362

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance, and to provide for a report on State health insurance safety-net programs.

IN THE HOUSE OF REPRESENTATIVES

June 25, 1999

Mr. ARMEY introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance, and to provide for a report on State health insurance safety-net programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Fair Care for the Uninsured Act of 1999'.

TITLE I--REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE

SEC. 101. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL- Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

`SEC. 35. HEALTH INSURANCE COSTS.

`(a) IN GENERAL- In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the amount paid during the taxable year for qualified health insurance for the taxpayer, his spouse, and dependents.

`(b) LIMITATIONS-

`(1) IN GENERAL- The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the sum of the monthly limitations for coverage months during such taxable year for each individual referred to in subsection (a) for whom the taxpayer paid during the taxable year any amount for coverage under qualified health insurance.

`(2) MONTHLY LIMITATION-

`(A) IN GENERAL- The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12 of--

`(i) $1,000 if such individual is the taxpayer,

`(ii) $1,000 if--

`(I) such individual is the spouse of the taxpayer,

`(II) the taxpayer and such spouse are married as of the first day of such month, and

`(III) the taxpayer files a joint return for the taxable year, and

`(iii) $500 if such individual is an individual for whom a deduction under section 151(c) is allowable to the taxpayer for such taxable year.

`(B) LIMITATION TO 2 DEPENDENTS- Not more than 2 individuals may be taken into account by the taxpayer under subparagraph (A)(iii).

`(C) SPECIAL RULE FOR MARRIED INDIVIDUALS- In the case of an individual--

`(i) who is married (within the meaning of section 7703) as of the close of the taxable year but does not file a joint return for such year, and

`(ii) who does not live apart from such individual's spouse at all times during the taxable year,

the limitation imposed by subparagraph (B) shall be divided equally between the individual and the individual's spouse unless they agree on a different division.

`(3) COVERAGE MONTH- For purposes of this subsection--

`(A) IN GENERAL- The term `coverage month' means, with respect to an individual, any month if--

`(i) as of the first day of such month such individual is covered by qualified health insurance, and

`(ii) the premium for coverage under such insurance for such month is paid by the taxpayer.

`(B) EMPLOYER-SUBSIDIZED COVERAGE- Such term shall not include any

month for which such individual participates in any subsidized health plan (within the meaning of section 162(l)(2)) maintained by any employer of the taxpayer or of the spouse of the taxpayer.

`(C) CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT BENEFICIARIES- Such term shall not include any month during a taxable year if any amount is not includible in the gross income of the taxpayer for such year under section 106 with respect to--

`(i) a benefit chosen under a cafeteria plan (as defined in section 125(d)), or

`(ii) a benefit provided under a flexible spending or similar arrangement.

`(D) MEDICARE AND MEDICAID- Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual--

`(i) is entitled to any benefits under title XVIII of the Social Security Act, or

`(ii) is a participant in the program under title XIX of such Act.

`(E) CERTAIN OTHER COVERAGE- Such term shall not include any month during a taxable year with respect to an individual if, at any

time during such year, any benefit is provided to such individual under--

`(i) chapter 17 of title 38, United States Code, or

`(ii) any medical care program under the Indian Health Care Improvement Act.

`(F) PRISONERS- Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

`(G) INSUFFICIENT PRESENCE IN UNITED STATES- Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

`(4) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS- In the case of a taxpayer who is eligible to deduct any amount under section 162(l) for the taxable year, this section shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

`(c) QUALIFIED HEALTH INSURANCE- For purposes of this section--

`(1) IN GENERAL- The term `qualified health insurance' means insurance which constitutes medical care as defined in section 213(d) without regard to--

`(A) paragraph (1)(C) thereof, and

`(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

`(2) EXCLUSION OF CERTAIN OTHER CONTRACTS- Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).

`(d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS-

`(1) IN GENERAL- If a deduction would (but for paragraph (2)) be allowed under section 220 to the taxpayer for a payment for the taxable year to the medical savings account of an individual, subsection (a) shall be applied by treating such payment as a payment for qualified health insurance for such individual.

`(2) DENIAL OF DOUBLE BENEFIT- No deduction shall be allowed under section 220 for that portion of the payments otherwise allowable as a deduction under section 220 for the taxable year which is equal to the amount of credit allowed for such taxable year by reason of this subsection.

`(e) SPECIAL RULES-

`(1) COORDINATION WITH MEDICAL EXPENSE DEDUCTION- The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 for the taxable year shall be reduced by the credit (if any) allowed by this section to the taxpayer for such year.

`(2) DENIAL OF CREDIT TO DEPENDENTS- No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

`(3) INFLATION ADJUSTMENT- In the case of any taxable year beginning in a calendar year after 2000, each dollar amount contained in subsection (b)(2)(A) shall be increased by an amount equal to--

`(A) such dollar amount, multiplied by

`(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting `calendar year 1999' for `calendar year 1992' in subparagraph (B) thereof.

Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $50 ($25 in the case of the dollar amount in subsection (b)(2)(A)(iii)).'

(b) INFORMATION REPORTING-

(1) IN GENERAL- Subpart B of part III of subchapter A of chapter 61 of such Code (relating to information concerning transactions with other persons) is amended by inserting after section 6050S the following new section:

`SEC. 6050T. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

`(a) IN GENERAL- Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such

individual or any other individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

`(b) FORM AND MANNER OF RETURNS- A return is described in this subsection if such return--

`(1) is in such form as the Secretary may prescribe, and

`(2) contains--

`(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

`(B) the name, address, and TIN of each individual who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage, and

`(C) such other information as the Secretary may reasonably prescribe.

`(c) CREDITABLE HEALTH INSURANCE- For purposes of this section, the term `creditable health insurance' means qualified health insurance (as defined in section 35(c)) other than--

`(1) insurance under a subsidized group health plan maintained by an employer, or

`(2) to the extent provided in regulations prescribed by the Secretary, any other insurance covering an individual if no credit is allowable under section 35 with respect to such coverage.

`(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED- Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing--

`(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

`(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

`(3) the information required under subsection (b)(2)(B) with respect to such payments.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

`(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS- Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).'.

(2) ASSESSABLE PENALTIES-

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xi) through (xvii) as clauses (xii) through (xviii), respectively, and by inserting after clause (x) the following new clause:

`(xi) section 6050T (relating to returns relating to payments for qualified health insurance),'.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking `or' at the end of the next to last subparagraph, by striking the period at the end of the last subparagraph and inserting `, or', and by adding at the end the following new subparagraph:

`(BB) section 6050T(d) (relating to returns relating to payments for qualified health insurance).'.

(3) CLERICAL AMENDMENT- The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050S the following new item:

`Sec. 6050T. Returns relating to payments for qualified health insurance.'.

(c) CONFORMING AMENDMENTS-

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period `, or from section 35 of such Code'.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

`Sec. 35. Health insurance costs.

`Sec. 36. Overpayments of tax.'.

(d) EFFECTIVE DATE- The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 102. ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL- Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

`SEC. 7527. ADVANCE PAYMENT OF HEALTH INSURANCE CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

`(a) GENERAL RULE- In the case of an eligible individual, the Secretary shall make payments to the provider of such individual's qualified health insurance equal to such individual's qualified health insurance credit advance amount with respect to such provider.

`(b) ELIGIBLE INDIVIDUAL- For purposes of this section, the term `eligible individual' means any individual--

`(1) who purchases qualified health insurance (as defined in section 35(c)), and

`(2) for whom a qualified health insurance credit eligibility certificate is in effect.

`(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE- For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to the Secretary which--

`(1) certifies that the individual will be eligible to receive the credit provided by section 35 for the taxable year,

`(2) estimates the amount of such credit for such taxable year, and

`(3) provides such other information as the Secretary may require for purposes of this section.

`(d) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT- For purposes of this section, the term `qualified health insurance credit advance amount' means, with respect to any provider of qualified health insurance, the Secretary's estimate of the amount of credit allowable under section 35 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider.

`(e) REGULATIONS- The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.'.

(b) CLERICAL AMENDMENT- The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

`Sec. 7527. Advance payment of health insurance credit for purchasers of qualified health insurance.'.

(c) EFFECTIVE DATE- The amendments made by this section shall take effect on January 1, 2000.

TITLE II--STUDY OF SAFETY-NET HEALTH INSURANCE PROGRAMS FOR THE MEDICALLY UNINSURABLE

SEC. 201. STUDY OF STATE SAFETY-NET HEALTH INSURANCE PROGRAMS FOR THE MEDICALLY UNINSURABLE.

(a) STUDY-

(1) IN GENERAL- The Secretary of Health and Human Services shall provide for a study on the current state of all existing State safety-net health insurance programs (as defined in subsection (c)). The study shall determine which forms of such programs are the most successful in making health insurance available to all willing payers regardless of their health status.

(2) CONSULTATION- In conducting the study the Secretary shall consult with representatives of the National Governors Association, the National Association of Insurance Commissioners, national associations representing health insurers, insurance companies that administer and participate in State safety-net health insurance programs, and individuals who receive their health insurance through such programs.

(b) REPORT- The Secretary shall submit to Congress, by not later than October 1, 2000, a detailed report on the study conducted under subsection (a). The report shall include recommendations on how Congress can best strengthen State safety-net health insurance programs where they currently exist and can encourage their establishment in States where they do not exist.

(c) STATE SAFETY-NET HEALTH INSURANCE PROGRAM DEFINED- For purposes of this section, the term `State safety-net health insurance program' means a high risk pool or similar arrangement provided under State law for providing access of medically uninsurable individuals to health insurance coverage. Such term may include such other arrangements as the Secretary finds appropriate for assuring the provision of health insurance coverage to such individuals.

END

SUMMARY
OF H.R. 2362

Fair Care for the Uninsured Act

A Summary of H.R. 2362

The Problem

Related Links

Response to Calls for Increased Health Care Regulation

Health Care Quality: Bureaucracy or Consumer Choice

Armey Responds to the President's Initiative

ClintonCare 1993 Bureaucracy Chart

Moral Equivalent of War 1993 memo

The Health Care Section of the Library

Americans increasingly find health insurance to be unavailable, unaffordable, or undesirable. Forty-four million Americans are uninsured involuntarily, and this number is rising by 100,000 per month. Those who have insurance are often frustrated by a lack of choice, control, portability, and affordability, leading to pressures for government mandates and bureaucracy.

The source of these problems lies in the tax code. There is a hidden health penalty tax that effectively punishes people who try to buy their insurance outside the workplace. This tax is unfair, rewarding the highly paid CEO with the rich company plan while punishing the waitress earning minimum wage whose employer can't afford to offer insurance or offers only "one crummy HMO." It's also wasteful, encouraging employees to think of their job-based health care as "free."

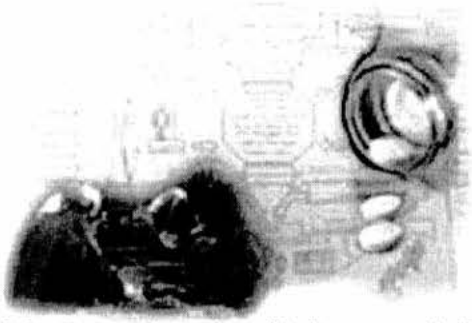
To solve these problems, the *Fair Care for the Uninsured Act* creates tax fairness. As a result, insurance will become more affordable and portable; more people will become insured; and consumers will have more choice and control.

Summary

The bill creates a new tax credit for the purchase of private health insurance, effective Jan. 1, 2000, of $1,000 for individuals and $500 for dependents, with a maximum $3,000 for a family.

- The credit is available to uninsured Americans (specifically, all persons who don't actually participate in a tax-subsidized employer health plan or Medicaid; don't receive VA or Indian health benefits; are not eligible for Medicare; are not in prison; and live in the US at least half the year).
- The credit can be used to buy any health-insurance policy that would be eligible for the existing health-care deduction (sec. 213 of the tax code). Dental-only, one-disease, and similar plans do not qualify.
- Individuals are free to choose their own benefits and cost-sharing features. The credit can be used with a Medical Savings Account.
- The credit is fully refundable, meaning it is available to persons who owe no tax liability, and advance-payable, meaning cash-strapped individuals can begin using it without waiting for a tax refund.
- The bill contains no tax increases or spending cuts.
- In order to help persons who are too sick to insure at rates that reflect their true risk, but are willing to pay more than what healthy people pay,

the bill directs the HHS Secretary to study and recommend ways to encourage states to help such persons through "high-risk pools" (currently operating in 28 states).



Affordable Health Care for the Uninsured: The Time is Now

A Memo from
House Majority Leader Dick Armey

January, 1999

The time has come to launch a new phase of the health-care debate. We who are dedicated to advancing freedom need to seize the initiative. We need to pass legislation that protects patients from genuine HMO abuses and ensures their access to timely medical care. We need to offer better solutions for giving the uninsured access to affordable health care. And we need to preserve the high quality of American health care from creeping mandates and socialized medicine. I believe we can achieve all of these goals -- and in the process win the hearts and minds of the American people on the health-care issue. Here, for your consideration, are some of my thoughts on how we can do this.

"We face a choice: we can remain passive as the political dynamic drives us toward an increasingly bureaucratic, government-controlled medical system; or we can take decisive action to create a consumer-driven health-care market that responds to patients' real needs."

The liberals' goal

We know the liberals' ultimate goal is government control. We also know that a bureaucratic, government-run system means lower-quality medical care for all of us in the long run. And we know that, while ClintonCare may have been rejected in 1994, the liberals are driving the country toward it, step by step. The Clinton Administration's recent, massive proposal to regulate every aspect of managed care is only the latest of these steps. The political problem for Members of Congress is that such regulatory proposals are fueled by voters' legitimate dissatisfaction with today's employment-based health-benefits system, with its lack of access, affordability, portability, and choice. Patients are not in the driver's seat; employers and insurers are. So it's no surprise to me that patients aggrieved by their HMO turn to government for redress: what other options do they have?

Giving trial lawyers new rights to sue health plans, as the President's allies want, would not address any of the real problems of today's system, and would in some ways make

them worse. In the long run, only reforms that liberate people to *choose* their health plans and doctors – and to take their business elsewhere when dissatisfied – can make the health system better and more satisfying for all of us.

Wisely, Congress recognized this truth when it rejected the Clinton plan last year. Instead, as you know, the House passed the Patient Protection Act (HR 4250), a bill that would impose tough accountability for HMOs, give employees more choices, and lower costs. While Senate Democrats succeeded in stopping the Patient Protection Act last fall, hoping to blame its demise on Republicans in an election year, I believe conditions are now ripe to produce a good bipartisan bill the President can sign. I hope and expect to call up such legislation in 1999, following due committee consideration.

The crisis of the uninsured

The current "patients' rights" debate is too narrow. It focuses only on how much new regulation and legal liability to impose on doctors, employers, and health plans. It misses the damage inevitably done by these sorts of intrusions, in the form of higher premium costs and lost coverage. To really help patients, we need to expand the discussion to include the growing *crisis of the uninsured.* After all, access to affordable health coverage is the *first* patient protection. Consider:

- At some point during the coming year, 43.4 million Americans will be without health coverage.
- A decade from now, that figure could be 53 million, or as many as 60 million if the economy softens.
- The number of the uninsured has grown by 10 million over the past ten years.
- Where 11 percent of the population was uninsured in 1980, today it's 16 percent, and ten years from now it could be 20 percent or higher.
- In my own state of Texas, 25 percent of the population is uninsured.
- More than 80 percent of the uninsured hold jobs and work year-round, mostly in small businesses. They make too much to qualify for Medicaid, and their employers offer them either no coverage or coverage they can't afford.

While the uninsured are not a monolithic mass – many go uncovered only briefly, others voluntarily for various legitimate reasons -- the hard fact is this: the *percentage* of the population going without insurance involuntarily is growing year after year, in good times and bad. This is clearly a structural problem we ignore at our peril.

What's causing the problem? The immediate cause is clear: Health costs have been rising dramatically, despite a brief slowdown in the mid-'90s. From 1988 to 1996, the cost of the average family health plan more than doubled, from $2,500 to $5,350. The next few years are expected to bring further double-digit increases.

But the deeper cause is the lack of a true consumer-driven market. Government policy has distorted the market practically out of existence. Layers of red tape, mandates, and price controls deny consumers the right to buy affordable insurance that best meets their needs. And as I try to explain below, a basic inequity in the tax code has caused third-party payment to become the norm. Since somebody else is paying the bill, people don't shop for the best prices and products.

The uninsured are victims of a classic vicious circle: Each new government intervention increases costs, which in turn swells the ranks of the uninsured, which in turn causes the public to call for yet more interventions, and so on. The way to break out of this cycle is to get more individual Americans into a true health-insurance market, where as consumers they'll demand lower prices and fewer interventions. And the only way to create that market is to go to the real root of the problem: the tax code.

Diagnosis: broken tax code

Big problems often have simple causes. The crisis of the uninsured flows ultimately from a single provision of the Internal Revenue Code: the method by which individuals obtain tax-favored health insurance. Under today's code, the only way an individual can obtain a tax benefit for health insurance is through the workplace. Health benefits provided by employers are excluded from income, that is, they are treated as if they are not really part of the individual's compensation. But health insurance purchased directly by the individual is not. This exclusion is both wasteful and unfair. It is wasteful because:

- Health care becomes an invisible benefit, seemingly free to employees.
- Employees become less cost-conscious.
- They demand unnecessary coverage and services.
- The whole medical system becomes wasteful and inefficient.
- Insurance becomes more costly than necessary.

At the same time, the exclusion is unfair because:

- People without access to job-based coverage get no tax benefit, and are thus more likely to be uninsured.
- Higher-paid people get a bigger subsidy than those with lower incomes. Uncle Sam gives the wealthy CEO a more generous subsidy than the waitress at the corner diner -- and if the diner can't afford to offer health benefits, she gets nothing at all. That's wrong.
- The majority of employees have little or no choice of plans or doctors, fueling frustration and anger and calls to Congress for relief.

Prescription: tax fairness

How can we fix these problems? Perhaps no one in Congress has spent more time thinking about that very question than Bill Thomas, in his capacity as chairman of the health subcommittee at Ways & Means. Bill advocates an elegantly simple solution: Replace the existing tax exclusion with a refundable Universal Tax Credit for insurance purchased by individuals, with very few if any strings attached. Give consumers a voucher of a fixed dollar amount and let them shop in the marketplace for the coverage that best suits their needs. If they want richer coverage, they are free to pay for it with after-tax dollars.

I strongly support this idea. It would give all Americans access to at least a minimum level of private health coverage. It would make health insurance truly portable between jobs. It would give people a real choice of plans and doctors. It would let dissatisfied patients "fire" their HMO. Indeed, it would take the steam out of the current movement to put managed care in shackles. And it would stop cold the liberals' endless efforts to expand government-run programs like Medicare and Medicaid to cover the entire U.S. population. It provides justice between rich and poor. It is, in short, *the* answer to the Health Question.

But a solution so simple and sweeping could also be politically challenging. We haven't the luxury of starting from a blank slate. And frankly we would be deluding ourselves if we thought we could achieve this major reform without causing at least some unease among folks who feel they're served well by the current system, mainly people with stable jobs at large companies.

An alternative, incremental approach would be to leave the existing exclusion untouched, but extend similar tax benefits -- either a credit or a deduction; my own preference is for a refundable credit -- to people who aren't eligible for an employer health plan. While not the complete answer, this would provide greater equity, access, portability, and choice than today's system, with little if any disruption. It would get people covered and begin creating a true marketplace.

In any event, the amount of the credit or deduction should be large enough to get millions of Americans covered. It should be substantial. If that seems "costly," in Washington terms, let's remember that the current federal surplus -- or more accurately, the tax over-payment -- is already being squandered by President Clinton and his liberal allies on Washington spending programs; it will soon all be spent, if we don't return it to the people in the form of tax cuts. Why not return some of it in a way that also helps alleviate the crisis of the uninsured? The American tax burden is now at its *highest level in history*. If we can't cut taxes now, when can we?

To paraphrase my political antipode, Senator Kennedy: Some say we can't afford to cover the uninsured; I say we can't afford not to. If the CEO is going to receive government-subsidized health care, then so should the waitress earning the minimum wage. Period.

My dream bill

At the risk of presumption, I'd like to go one step further here. I would like to suggest a possible consumer-protection package that I believe could win bipartisan support and a presidential signature. My dream bill would include none of the costly mandates of the liberals' plan:

- No body-part mandates.
- No any-willing-provider mandates.
- No sue-your-health-plan provision.

But it *would* include the Patient Protection Act's tough Talent-Norwood accountability provision, which provides for a mandatory review of disputed HMO treatment decisions by external, independent medical specialists. This offers a better approach than the sue-your-health-plan scheme; sick people need to be in a hospital room, not a courtroom – receiving health care up-front to prevent injuries, not seeking damages for injuries already incurred.

At the same time, my dream bill would address the growing crisis of the uninsured through such exciting and innovative ideas as:

- Medical Savings Accounts for all, to give people more control of their health dollars.
- HealthMarts and HealthUnions, to enable small businesses to pool together to give their workers more affordable choices and a more generous menu of plans and doctors -- akin to the Federal Employees Health Benefit Program enjoyed by Members of Congress.
- Medical malpractice reform, to reduce wasteful defensive-medicine costs.
- And most importantly, tax fairness for the uninsured, as discussed above.

Conclusion

We face a choice: we can remain passive as the political dynamic drives us toward an increasingly bureaucratic, government-controlled medical system; or we can take decisive action to create a consumer-driven health-care market that responds to patients' real needs. I say the time has come to create the market. We should pass legislation that addresses in one bold stroke all of the basic problems generating today's frustrations with managed care and the employer-based system: the lack of access, affordability, portability, and choice. We should equalize the tax treatment of health benefits and thus liberate consumers to shop freely for affordable health care for their families. Whether we do this through a Universal Tax Credit that replaces the existing tax exclusion, or some new tax benefit for the uninsured, we still come out winners. We win the health debate -- and the hearts and minds of voters -- for generations to come.

Related Links:

Response to Calls for Increased Health Care Regulation

Health Care Quality: Bureaucracy or Consumer Choice

Armey Responds to the President's Initiative

ClintonCare 1993 Bureaucracy Chart

Moral Equivalent of War 1993 memo

The Health Care Section of the Library

THE LIBRARY

Armey Reacts to Calls for Increased Health Care Regulation

January 14, 1998

Today House Majority Leader Dick Armey made the following comments after the President and Congressional Democrats called for increased health care regulation:

Related Links

Response to Calls for Increased Health Care Regulation

Health Care Quality: Bureaucracy or Consumer Choice

Armey Responds to the President's Initiative

ClintonCare 1993 Bureaucracy Chart

Moral Equivalent of War 1993 memo

The Health Care Section of the Library

"Last fall when President Clinton appointed a commission to examine means of assuring quality care, I hoped we would witness an open, thoughtful debate. A commission thoroughly examining the options couldn't help but recognize that expanding choice and competition are key to maintaining and improving quality.

"But Democrats couldn't wait for a thoughtful commission to do its work. Instead, they are jumping the gun, calling for massive new government regulations before the presidential commission even meets to examine the idea. Making health plans more expensive and limiting choice and competition are exactly the wrong way to go.

"Like a typical Washington commission, the President's advisors responded to families' frustrations with managed care rules and regulations by proposing a deluge of new rules and regulations.

"Their approach calls for at least 1,372 new federal mandates. The last thing Americans need is more red tape putting bureaucrats in charge of their health care. We need to expand choice so every American can seek the best option and demand quality care."

"The President's new crusade reminds me of the old adage, if you don't learn from your mistakes you are bound to repeat them."

-- House Majority Leader Dick Armey responds to the president, 11/20/97

THE LIBRARY

Affordable Health Care for the Uninsured: The Time Is Now

Speech as prepared for delivery before the American Hospital Association
by House Majority Leader Dick Armey
February 1, 1999

I'm truly honored to have this opportunity to talk to you about health care in Congress this year.

"I believe the time has come for a whole new approach to health care. I think we can offer better solutions for the uninsured, help end frustrations with HMOs, and preserve the high quality of American medicine -- all at the same time."

Related Links

Response to Calls for Increased Health Care Regulation

Health Care Quality: Bureaucracy or Consumer Choice

Armey Responds to the President's Initiative

ClintonCare 1993 Bureaucracy Chart

Moral Equivalent of War 1993 memo

The Health Care Section of the Library

But before I do, I'd like to take a moment to comment on the President's budget. As you know, he's submitting it today. I think we can expect he'll propose a massive spending increase and a net tax *increase*. Think about that. Out of $4 trillion in projected surpluses over the next 15 years, the President can't find one penny for tax cuts. Instead, he wants to use that money to increase spending by 1 trillion dollars -- more than the Great Society. He's willing to see you and me overcharged for each of the next 15 years, but he doesn't want to give us a refund.

Now, when my wife and I get a phone bill that overcharges us, we don't just accept it, we get upset -- and demand a refund. And I'm sure you'll appreciate the irony here. The very same Administration that is aggressively enforcing the False Claims Act against hospitals for alleged overcharges can't see fit to refund its *own* overcharges to the American people.

Ladies and gentlemen, you do your best not to overcharge your customers. And Uncle Sam should show us the same level of decency and respect.

After all, this wonderful surplus did not appear out of thin air. It's not the government's money. It belongs to the American people. We earned it. We paid it. And it's ours.

And right now, the tax burden on the American people is at an all-time high -- higher than during World War II. If we can't cut taxes now, when can we?

That's why I'm launching a comprehensive campaign to thwart the President's historic money grab. My proposal is simple: Every tax in America should be cut by 10 percent. That's every tax, from the income tax, to the smallest municipal levy -- with only one exception: the Social Security tax. We need that to save Social Security. But cut every other tax by 10 percent, and we'll still have plenty of money with which to shore up Medicare and meet our other priorities.

Now as for health care, it's going to be a busy year. I expect the House to take up three -- maybe four -- important health-care bills this year. First, a bill by Chairman Thomas to protect the privacy of patient medical records. This is an excellent bill. And the House has passed it once already. Second, a bill to fix a few small glitches in the Medicare-Plus-Choice program that we created in the Balanced Budget Act of 1997. This will come out of Mike Bilirakis's health subcommittee of the Commerce committee. Third, the Patient Protection Act. Chairman Bilirakis will be re-introducing this bill tomorrow. As you know, we passed it in the House last summer, with your help and indeed with your support. And I want to thank you for that.

We want to work closely with you to get this patient-protection legislation enacted, because you understand even better than we do the anxiety that families feel when their loved ones' health care is at stake. We want to help relieve families of that anxiety. And in order for us to do this, we must all work together, in a bipartisan fashion. We'll have to set aside our differences and compromise. For example, on the so-called liability issue, we're going to have to settle for some form of mandatory external review. Quite frankly, the precious right to review comes before the lawyers' right to sue.

Now, there's one other possible bill we might take up this year - and this is only a remote possibility -- namely, a bill to update and improve Medicare. I totally agree with Senator Breaux and Chairman Thomas that we should transform Medicare into a common-sense program like the one that Members of Congress enjoy. And I commend Senator Breaux for his courage in taking on the left wing of his own party. Wouldn't it be inspiring if President Clinton showed similar leadership? Really, it's sad to see such a deep schism in the Democratic party. And I have to wonder: Is the left wing of their party really so stuck in 1960s that they aren't willing to change to keep this program alive for the next century?

Now, there's another problem I hope to see us address this year. And that's the growing numbers of the uninsured. Right now, that number is 43 million. A decade from now, it could be 53 million, or 60 million if the economy softens. In our haste to protect patients from health-plan abuses, we shouldn't forget about what mandates and higher costs mean for the millions Americans who don't even have the first patient protection -- health coverage.

Of course, I don't have to tell this audience about the growing number of the uninsured. You see them every day. You treat them in the emergency room, after their illness has already become a crisis. And you do so free of charge, at great cost to yourselves and to the rest of us. There's something wrong when the richest nation on earth, with the best health-care system in the world, the lowest poverty, and the lowest unemployment, has a constantly growing percentage of our population going without insurance because it isn't affordable.

Ladies and gentlemen, I believe the time has come for a whole new approach to health care. I think we can offer better solutions for the uninsured, help end frustrations with HMOs, and preserve the high quality of American medicine -- all at the same time. How? By shifting more choice and control to patients, so they can take more responsibility for their health care -- and take their business elsewhere when dissatisfied.

It's no secret why people are frustrated, or why they're calling on Congress for relief. Virtually all of today's problems in health care can be traced back to one

source: the lack of a consumer-driven market. And the main source of that problem is the tax code. Millions of Americans are innocent victims of what I call the Health Penalty Tax. They're actually punished for trying to buy their insurance on their own, outside the workplace. Just as the Marriage Penalty Tax punishes people for doing the right thing and getting married, the Health Penalty Tax punishes people for doing the right thing and buying their own insurance. And what's worse, this tax falls hardest on the lowest-income workers and the unemployed. That's not fair. But happily, this injustice *can* be remedied.

And that's why I'm proud today to announce that I am drafting legislation to restore tax fairness for the uninsured. I hope to introduce it within the next few weeks. The bill I'm drafting would create a refundable tax credit - -- a voucher, in effect -- for the purchase of health insurance by people who are uninsured. It would be available to people who aren't eligible to get coverage through the workplace. The voucher would be worth an amount that's equivalent to the value of the current tax exclusion for employer-provided benefits. So it restores tax fairness and, in effect, repeals the Health Penalty Tax.

People could use the voucher to shop for a basic plan that best suits their needs. If they want more generous coverage, they could buy it with after-tax dollars. And of course the states could supplement the credit. Now, for most people, the voucher won't cover the whole cost of insurance. But that's okay. It's intended to provide just enough help to encourage people to buy insurance who would otherwise be unlikely to do so. Folks who choose to remain uninsured won't get the credit.

Now, let's think about what this one simple reform would do. For one thing, it would give 43 million uninsured Americans access to a modest level of private coverage. It would give them access to insurance that's portable. And it would give them a real choice of plans. Best of all, it would give them the power to keep their doctor and fire their HMO -- instead of the other way around.

And of course, we shouldn't stop there. I think we should give consumers additional tools -- I'm thinking of innovative ideas like Medical Savings Accounts, HealthMarts, HealthUnions, and medical-malpractice reform. With these reforms, we can go far toward creating a true consumer-driven marketplace for the 21st century. And no one knows better than this audience what it will mean to have more people with health insurance. It will mean fewer sick people arriving at the emergency room, and more healthy people getting preventive care. In closing, if I may be permitted to echo the rhetorical style of my political opposite, Senator Kennedy: Some say we can't afford to restore tax fairness for the uninsured -- I say we can't afford not to. If the wealthy CEO is going to receive government-subsidized health care, then so should the waitress earning the minimum wage. Period.

Thank you.

Bill Summary & Status for the 106th Congress

Item 2 of 37

PREVIOUS BILL | NEXT BILL
PREVIOUS BILL:ALL | NEXT BILL:ALL
NEW SEARCH | HOME | HELP

H.R.2458
SPONSOR: **Rep Stark, Fortney Pete** (introduced 07/01/99)

Jump to: Titles, Status, Committees, Amendments, Cosponsors, Summary

TITLE(S):

- OFFICIAL TITLE AS INTRODUCED:
  A bill to amend the Internal Revenue Code of 1986 to provide a refundable caregivers tax credit.

STATUS: Floor Actions

NONE

STATUS: Detailed Legislative Status

House Actions

Jul 1, 99:
Referred to the House Committee on Ways and Means.

STATUS: Congressional Record Page References

NONE

COMMITTEE(S):

- COMMITTEE(S) OF REFERRAL:
  House Ways and Means

AMENDMENT(S):

NONE

COSPONSORS(1):

Rep Markey, Edward J. - 07/01/99

SUMMARY:

NONE

THIS SEARCH	*THIS DOCUMENT*	*GO TO*
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

No bills were found with the number H.R.2458

The bill database is not updated as quickly as the Congressional Record. It is possible that the bill has not yet been entered into the database.

INTRODUCTION OF HEALTH INSURANCE FOR AMERICANS ACT OF 1999: LEGISLATION TO PROVIDE REFUNDABLE TAX CREDITS FOR THE PURCHASE OF HEALTH INSURANCE THROUGH A FEHBP-TYPE POOLING ARRANGEMENT -- HON. FORTNEY PETE STARK (Extension of Remarks - June 15, 1999)

[Page: E1254]

HON. FORTNEY PETE STARK

in the House of Representatives

TUESDAY, JUNE 15, 1999

- Mr. STARK. Mr. Speaker, the biggest social problem facing America today is that one in six of our fellow citizens have no health insurance and are all too often unable to afford health care.

- About 44 million Americans have no health insurance. Despite the unprecedented good economic times, the number of uninsured is rising about 100,000 a month. It is unimaginable what will happen if and when the economy slows and turns down. One health research group, the National Coalition on Health Care, has estimated that with rising health insurance costs and an economic downturn, the number of uninsured in the year 2009 would be about 61.4 million.

- The level of un-insurance among some groups is even higher. For example, in California it is estimated that nearly 40% of the Hispanic community is uninsured.

- An article by Robert Kuttner in the January 14, 1999 New England Journal of Medicine entitled `The American Health Care System,' describes the problem well: `The most prominent feature of American health insurance coverage is its slow erosion, even as the government seeks to plug the gaps in coverage through such new programs as Medicare+Choice, the Health Insurance Portability and Accountability Act (HIPAA), expansions of state Medicaid programs, and the $24 billion Children's Health Insurance Program of 1997. Despite these efforts, the proportion of Americans without insurance increased from 14.2% in 1995 to 15.3% in 1996 and to 16.1% in 1997, when 43.4 million people were uninsured. Not as well appreciated is the fact that the number of people who are under-insured, and thus must either pay out of pocket or forgo medical care, is growing even faster.'

- Does it matter whether people have health insurance? Of course it does. No health insurance all too often means important health care foregone, with a minor sickness turning into a major, expensive illness, or a warning sign ignored until it is fatal. Lack of insurance is a major cause of personal bankruptcy. It has forced us to develop a crazy, Rube Goldberg system of cross-subsidies to keep the `safety net' hospital providers afloat.

- Mr. Speaker, what is wrong with us? No other modern, industrialized nation fails to insure all its people. I don't believe we are incompetent, but our failure to provide basic health insurance to all our citizens is a national disgrace.

- Personally, I would like to see all Americans have health insurance through an expansion of Medicare to everyone. I am also a co-sponsor of Rep. **McDermott**'s single payer type program, which is modeled on Canada's success in insuring all its people for about 30% less than we spend to insure only 84% of our citizens.

- But these efforts are not likely to succeed in an conservative Congress or in a closely-divided Congress.

- Therefore, yesterday I introduced legislation, H.R. 2185, to try another approach--a refundable tax credit approach--which I believe can be made to work and which is similar to a number of bills recently introduced by various Republican members.

- Unfortunately, many of these earlier tax credit bills don't work. They either throw money at people who already have health insurance (e.g., 100% tax deductions for health insurance for small employers), provide a pitiful amount of money that wouldn't buy a fig leaf of a policy (e.g., a $500 credit bill), or if they do provide enough money, waste it by providing no `pool' or `wholesale' market and forcing people into the retail market where insurance companies take 20-30% off the top, refuse to insure the sick, and raise rates on older people so that the credit is woefully inadequate.

- The failures in these bills can be addressed. I think my proposal solves many of these problems. The idea of a tax credit approach to ending the national disgrace of un-insurance is a new one, however, and we desperately need a series of detailed, thoughtful hearings to design a program that will provide real help and not waste scarce resources on middlemen.

- The Health Insurance for Americans Act I introduced:

- Provides in 2001 and thereafter a refundable tax credit of $1200 per adult, $600 per child, and $3600 total per family. These amounts are adjusted for inflation at the same rate that the Federal government's plan for its employees (FEHBP) increases.

- The credit is available to everyone who is not participating in a subsidized health plan or eligible for Medicare.

- The credit may only be used to buy `qualified' health insurance, which is defined to be private insurance sold through a new HHS Office of Health Insurance (OHI) in the same general manner that Federal employees `buy' health insurance through the Office of Personnel Management.

- Any insurer who wants to sell to Federal workers through FEHBP must also offer to sell one or more policies through OHI. OHI will hold an annual open enrollment period (similar to FEHBP's fall open enrollment) and insurers must sell a policy similar to that which they offer to Federal workers (but may also offer a zero premium policy), for which there is no-pre-existing condition exclusion or waiting period, for which the premium and quality may be negotiated between the carrier and OHI, and which must be community-rated (i.e., it won't rise in price as individuals age).

- Mr. Speaker, a refundable tax credit sounds like an easy idea, but as in all things in America's $1.1 trillion health care system, there are some serious problems that have to be addressed.

- The major problems with a refundable credit are:

- (1) How to get the money to the uninsured in advance, so that the uninsured, who tend to be lower income, can buy a policy without waiting for a refundable credit?

- (2) How to make sure that the credit is spent on health insurance and there is no tax fraud?

- I solve both of these problems through credit advances to insurers administered through OHI.

- (3) How to limit the credit to those who are uninsured, and avoid encouraging employers and those buying private insurance on their own from substituting the credit for their current coverage?

- By limiting the size of the credit, most people who have insurance through the workplace or are participating in public programs will want to continue with their current coverage. The credit is adequate to ensure a good health insurance plan, but most workers and employers will want to continue with the current system.

- Having said this, there is no question that this credit is likely to erode gradually the employer-based system. It is hard to see employers wanting to offer new employees a health plan, when they can use this new public plan. Indeed, it is likely that an employer will say, `I will pay you more in salary if you will go use the tax credit program.'

- But is this bad? The employer-based health insurance system is an historical accident of wage controls during World War II where in lieu of higher wages, people were able to get health insurance as a fringe benefit. This system is collapsing. No one today would ever design from scratch such a system where your family's health care depended on where you worked. It is, frankly, probably good that this system would gradually erode--if there is something to replace it. The Health Insurance for Americans Act provides that replacement. To the extent that workers have better health care through their employer, the employer can continue to provide increased pay for the purchase of `supplemental' or `wrap-around' health benefits and can even help arrange such additional policies for their workers--and both workers and employers come out ahead.

- The bill I am introducing does not force an overnight revolution in the employer-provided system. But the current system is dying, and my bill provides a transition to a new system in which employees will have individual choice of a wide range of insurers (instead of today's reality, where most employees are offered one plan and only one plan).

- (4) How to make the credit effective by allowing the individual to buy `wholesale' or at group rates, rather than `retail' or individual rates?

- (5) How to make sure that individual who most need health insurance--those who have been sick--are able to use the credit to obtain affordable insurance?

- (6) How to minimize the problem created when the healthiest individuals take their credit and buy policies which are `good' for them (e.g., Medical Savings Accounts), but `bad' for society

- because they leave the sicker in a smaller, more expensive insurance pool (that is, how do we keep the insurance pool as large as possible and avoid segmentation and an `insurance death' spiral)?

- Again, the OHI/FEHBP idea largely solves these 3 problems, by giving individuals a forum where they can comparison shop for a variety of plans that meet the standards of the OHI and achieve efficiencies of scale and reduced overhead.

- These questions are the single biggest problem facing the refundable credit proposal. Even if we are able to `pool' the individuals, will insurers offer an affordable policy to a group which they may fear will have a disproportionate number of very sick individuals?

- We may need to develop a national risk pool `outlet' to take the expensive risks and subsidize them in a separate pool, so that the cost of premiums for most of the people using OHI is

affordable. Another alternative, and probably the one that makes the most sense for society, is to mandate that individuals participate in the OHI pool (if they don't have similar levels of insurance elsewhere). Only by getting everyone to participate can we ensure a decent price by spreading the risk. The danger that young, healthy individuals will ignore (forego) the tax credit program may be serious enough that it will cause insurers to price the OHI policies too high, thus starting an insurance `death spiral' as healthier people refuse to participate and rates start rising to cover the costs of the shrinking pool of sicker-than-average individuals.

- As I said earlier, the different Republican tax credit proposals fail to deal with these key questions and problems. But their bills have helped focus us on this national crisis. Through hearings and studies, I hope we can find ways to ensure that these technical--but very important questions--are addressed.

- There is one key, monstrous question left: how to pay for the refundable credit so we may end the national disgrace of 44 million uninsured?

- I have not addressed this issue in the bill, but am willing to offer a number of options. I would like to see the temporary budget surpluses used to start this program--but those surpluses are temporary and we need a permanent financing source.

- The problem of the uninsured is largely due to the fact that many business refuse or are unable to provide health insurance to their workers. The fairest way to finance this program would be a tax on businesses which do not provide an equivalent amount of insurance to their workers. Such a tax, of course, would slow the tendency of this program to encourage businesses to drop coverage. Since many small businesses could not afford the tax, we will need to subsidize them.

- Another approach would be to apply the next minimum wage increase to the payment of health insurance premiums by those firms which do not offer insurance. A 50 cent per hour minimum wage increase dedicated to health insurance would pay most of an individual's premium.

- Other financing sources could be a provider and insurer surtax, since these groups will no longer need to be subsidize the uninsured and will be receiving tens of billions in additional income. Finally, to end the national disgrace of un-insurance, a small national sales or VAT tax would be in order.

- Again, Mr. Speaker, I have said that the earlier tax credit proposals have serious structural problems. The biggest problem they have is not saying how they will pay for their plans. Until Members talk about financing, all of these plans are sound and fury, signifying nothing.

- These tax credit bills are obviously expensive, but so is the cost of 1 in 6 Americans being uninsured. In deaths, increased disability and morbidity, and more expensive use of emergency rooms, American society pays for the uninsured. If we could end the national disgrace of un-insurance, we would save billions in improved productivity, reduced provider costs, bad debt, personal bankruptcy, and disproportionate share hospital payments.

- Mr. Speaker, it is time for America to join the rest of the civilized world and provide health insurance for all its citizens.

[Page: E1255]

END

THIS SEARCH	THIS DOCUMENT	GO TO
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

H.R.2185

Health Insurance for Americans Act of 1999 (Introduced in the House)

HR 2185 IH

106th CONGRESS

1st Session

H. R. 2185

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance through a pooling arrangement.

IN THE HOUSE OF REPRESENTATIVES

June 14, 1999

Mr. STARK introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance through a pooling arrangement.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Health Insurance for Americans Act of 1999'.

TITLE I--REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE

SEC. 101. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL- Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

`SEC. 35. HEALTH INSURANCE COSTS.

`(a) IN GENERAL- In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the amount paid during the taxable year for qualified health insurance for the taxpayer, his spouse, and dependents.

`(b) LIMITATIONS-

`(1) IN GENERAL- The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the sum of the monthly limitations for coverage months during such taxable year for each individual referred to in subsection (a) for whom the taxpayer paid during the taxable year any amount for coverage under qualified health insurance.

`(2) MONTHLY LIMITATION-

`(A) IN GENERAL- The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12 of--

`(i) $1,200 if such individual is the taxpayer,

`(ii) $1,200 if--

`(I) such individual is the spouse of the taxpayer,

`(II) the taxpayer and such spouse are married as of the first day of such month, and

`(III) the taxpayer files a joint return for the taxable year, and

`(iii) $600 if such individual is an individual for whom a deduction under section 151(c) is allowable to the taxpayer for such taxable year.

`(B) LIMITATION TO 2 DEPENDENTS- Not more than 2 individuals may be taken into account by the taxpayer under subparagraph (A)(iii).

`(C) SPECIAL RULE FOR MARRIED INDIVIDUALS- In the case of an individual--

`(i) who is married (within the meaning of section 7703) as of the close of the taxable year but does not file a joint return for such year, and

`(ii) who does not live apart from such individual's spouse at all times during the taxable year,

the limitation imposed by subparagraph (B) shall be divided equally between the individual and the individual's spouse unless they agree on a different division.

THIS SEARCH	*THIS DOCUMENT*	*GO TO*
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

THIS SEARCH	THIS DOCUMENT	GO TO
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

H.R.2185

Health Insurance for Americans Act of 1999 (Introduced in the House)

`(3) COVERAGE MONTH- For purposes of this subsection--

`(A) IN GENERAL- The term `coverage month' means, with respect to an individual, any month if--

`(i) as of the first day of such month such individual is covered by qualified health insurance, and

`(ii) the premium for coverage under such insurance for such month is paid by the taxpayer.

`(B) EMPLOYER-SUBSIDIZED COVERAGE- Such term shall not include any month for which such individual participates in

any subsidized health plan (within the meaning of section 162(l)(2)) maintained by any employer of the taxpayer or of the spouse of the taxpayer.

`(C) CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT BENEFICIARIES- Such term shall not include any month during a taxable year if any amount is not includible in the gross income of the taxpayer for such year under section 106 with respect to--

`(i) a benefit chosen under a cafeteria plan (as defined in section 125(d)), or

`(ii) a benefit provided under a flexible spending or similar arrangement.

`(D) MEDICARE AND MEDICAID- Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual--

`(i) is entitled to any benefits under title XVIII of the Social Security Act, or

`(ii) is a participant in the program under title XIX of such Act.

`(E) CERTAIN OTHER COVERAGE- Such term shall not include any month during a taxable year with respect to an individual if, at any time during such year, any benefit is provided to such individual under--

`(i) chapter 17 of title 38, United States Code, or

`(ii) any medical care program under the Indian Health Care Improvement Act.

`(F) PRISONERS- Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

`(G) INSUFFICIENT PRESENCE IN UNITED STATES- Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

`(4) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS- In the case of a taxpayer who is eligible to deduct any amount under section 162(l) for the taxable year, this section shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

`(c) QUALIFIED HEALTH INSURANCE- For purposes of this section, the term `qualified health insurance' means insurance sold through the Office of Health Insurance under title II of the Health Insurance for Americans Act of 1999.

`(d) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT-

`(1) RECAPTURE OF EXCESS ADVANCE PAYMENTS- If any payment is made by the Secretary under section 7527 during any calendar year to a provider of qualified health insurance for an individual, then the tax imposed by this chapter for the individual's last taxable year beginning in such calendar year shall be increased by the aggregate amount of such payments.

`(2) RECONCILIATION OF PAYMENTS ADVANCED AND CREDIT ALLOWED- Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit (other than the credit allowed by subsection (a)) allowable under this subpart.

`(e) SPECIAL RULES-

`(1) COORDINATION WITH MEDICAL EXPENSE DEDUCTION- The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 for the taxable year shall be reduced by the credit (if any) allowed by this section to the taxpayer for such year.

THIS SEARCH	*THIS DOCUMENT*	*GO TO*
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

H.R.2185

Health Insurance for Americans Act of 1999 (Introduced in the House)

`(2) DENIAL OF CREDIT TO DEPENDENTS- No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

`(3) INFLATION ADJUSTMENT-

`(A) IN GENERAL- In the case of any taxable year beginning in a calendar year after 2001, each dollar amount contained in subsection (b)(2)(A) shall be increased by an amount equal to--

`(i) such dollar amount, multiplied by

`(ii) the average of the inflation adjustments for the calendar year in which the taxable year begins and the preceding 4 calendar years.

Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $50.

`(B) INFLATION ADJUSTMENT- For purposes of subparagraph (A), the inflation adjustment for any calendar year is the percentage (if any) by which--

`(i) the weighted average FEHBP cost for the preceding calendar year, exceeds

`(ii) the weighted average FEHBP cost for second preceding calendar year.

`(C) WEIGHTED AVERAGE FEHBP COST- For purposes of subparagraph (B), the weighted average FEHBP cost for any calendar year is the weighted average determined under section 8906(a)(1)(A) of title 5, United States Code, as of October 1 of such calendar year based on the subscription charges that will be in effect during the following contract year.'

(b) INFORMATION REPORTING-

(1) IN GENERAL- Subpart B of part III of subchapter A of chapter 61 of such Code (relating to information concerning transactions with other persons) is amended by inserting after section 6050S the following new section:

`SEC. 6050T. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

`(a) IN GENERAL- Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

`(b) FORM AND MANNER OF RETURNS- A return is described in this subsection if such return--

`(1) is in such form as the Secretary may prescribe, and

`(2) contains--

`(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

`(B) the name, address, and TIN of each individual who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage, and

`(C) such other information as the Secretary may reasonably prescribe.

`(c) CREDITABLE HEALTH INSURANCE- For purposes of this section, the term `creditable health insurance' means qualified health insurance (as defined in section 35(c)) other than--

`(1) insurance under a subsidized group health plan maintained by an employer, or

`(2) to the extent provided in regulations prescribed by the Secretary, any other insurance covering an individual if no credit is allowable under section 35 with respect to such coverage.

`(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED- Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing--

`(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

---

THIS SEARCH	*THIS DOCUMENT*	*GO TO*
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

THIS SEARCH
Next Hit
Prev Hit
Hit List

THIS DOCUMENT
Forward
Back
Best Sections
Doc Contents

GO TO
New Bills Search
HomePage
Help

H.R.2185

Health Insurance for Americans Act of 1999 (Introduced in the House)

`(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

`(3) the information required under subsection (b)(2)(B) with respect to such payments.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

`(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS- Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).'.

(2) ASSESSABLE PENALTIES-

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xi) through (xvii) as clauses (xii) through (xviii), respectively, and by inserting after clause (x) the following new clause:

`(xi) section 6050T (relating to returns relating to payments for qualified health insurance),'.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking `or' at the end of the next to last subparagraph, by striking the period at the end of the last subparagraph and inserting `, or', and by adding at the end the following new subparagraph:

`(BB) section 6050T(d) (relating to returns relating to payments for qualified health insurance).'.

(3) CLERICAL AMENDMENT- The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050S the following new item:

`Sec. 6050T. Returns relating to payments for qualified health insurance.'.

(c) CONFORMING AMENDMENTS-

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period `, or from section 35 of such Code'.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

`Sec. 35. Health insurance costs.

`Sec. 36. Overpayments of tax.'.

(d) EFFECTIVE DATE- The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

SEC. 102. ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL- Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

`SEC. 7527. ADVANCE PAYMENT OF HEALTH INSURANCE CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

`(a) GENERAL RULE- In the case of an eligible individual, the Secretary shall make payments to the provider of such individual's qualified health insurance equal to such individual's qualified health insurance credit advance amount with respect to such provider.

`(b) ELIGIBLE INDIVIDUAL- For purposes of this section, the term `eligible individual' means any individual--

`(1) who purchases qualified health insurance (as defined in section 35(c)), and

`(2) for whom a qualified health insurance credit eligibility certificate is in effect.

`(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE- For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to the Secretary which--

`(1) certifies that the individual will be eligible to receive the credit provided by section 35 for the taxable year,

`(2) estimates the amount of such credit for such taxable year, and

---

THIS SEARCH	THIS DOCUMENT	GO TO
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

H.R.2185

Health Insurance for Americans Act of 1999 (Introduced in the House)

`(3) provides such other information as the Secretary may require for purposes of this section.

`(d) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT- For purposes of this section, the term `qualified health insurance credit advance amount' means, with respect to any provider of qualified health insurance, the Secretary's estimate of the amount of credit allowable under section 35 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider.

`(e) REGULATIONS- The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.'.

(b) CLERICAL AMENDMENT- The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

`Sec. 7527. Advance payment of health insurance credit for purchasers of qualified health insurance.'.

(c) EFFECTIVE DATE- The amendments made by this section shall take effect on January 1, 2001.

TITLE II--MAKING HEALTH INSURANCE COVERAGE AVAILABLE

SEC. 201. REQUIREMENT FOR OFFERING BY CARRIERS PARTICIPATING IN THE FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM (FEHBP).

(a) IN GENERAL- As a condition for entering into a contract for the offering of a health benefits plan under FEHBP on and after January 1, 2001, if the carrier offering the plan is a health insurance issuer the carrier offering the plan--

(1) shall make available qualified health insurance under this title to qualified individuals;

(2) shall provide for an annual open enrollment period (consistent with section 202(c)) during which such individuals may enroll in such insurance; and

(3) shall permit enrollment at other times and may impose (with respect to enrollment at such times) a waiting period of not longer than 60 days.

(b) QUALIFIED HEALTH INSURANCE DEFINED- For purposes of this title, the term `qualified health insurance' means, with respect to a carrier, health insurance coverage--

(1) that provides benefits that are the same as (or actuarially equivalent to) the benefits offered by

the carrier under a health benefits plan under FEHBP;

(2) for which there is no pre-existing exclusion or waiting period (except as permitted under subsection (a)(3)); and

(3) for which the premiums charged and quality of care standards are negotiated between the carrier and the Office of Health Insurance established under section 202 and for such which the premiums are established and applied on a uniform, community-rated basis.

(c) VARIATION IN BENEFITS- The benefits offered under qualified health insurance may vary from those offered by the carrier under FEHBP but only insofar as the Director of the Office of Health Insurance determines that such variation does not result in improper favorable selection. Such variation shall be permitted to enable the carrier to offer health insurance coverage the premium for which is equal to the credit amount available under section 35 of the Internal Revenue Code of 1986 and which does not require a premium payment by the qualified individual.

(d) QUALIFIED INDIVIDUAL DEFINED- For purposes of this title, the term `qualified individual' means an individual who is eligible for an income tax credit under section 35 of the Internal Revenue Code of 1986 for the purchase of qualified health insurance.

(e) ADDITIONAL DEFINITIONS- For purposes of this title:

(1) CARRIER- The term `carrier' has the meaning given such term in section 8901 of title 5, United States Code.

(2) FEHBP- The term `FEHBP' means the program of health benefits offered under chapter 89 of title 5, United States Code.

(3) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER- The terms `health insurance coverage' and `health insurance issuer' have the meanings given such terms in paragraphs (1) and (2) of section 9832(b) of the Internal Revenue Code of 1986.

THIS SEARCH	*THIS DOCUMENT*	*GO TO*
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

THIS SEARCH	THIS DOCUMENT	GO TO
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

H.R.2185

Health Insurance for Americans Act of 1999 (Introduced in the House)

SEC. 202. OFFICE OF HEALTH INSURANCE.

(a) ESTABLISHMENT- The Secretary of Health and Human Services shall establish an Office of Health Insurance (in this title referred to as the `Office'), to be headed by a Director (in this title referred to as the `Director') appointed by the Secretary.

(b) FUNCTIONS- In relation to carrying out section 201, the Office and the Director shall have the same authorities as the Office of Personnel Management and the Director of such Office have in carrying out FEHBP. The Office shall be responsible for the offering to qualified individuals of qualified health insurance made available under such section.

(c) PROVISION OF INFORMATION- The Director shall be responsible for the distribution of such information (including information in comparative form) and the conduct of a coordinated annual open enrollment period in a manner designed to encourage competition and facilitate consumer choice among the qualified health insurance offered under this title.

SEC. 203. EFFECTIVE DATE.

This title takes effect on January 1, 2001.

Bill Summary & Status for the 106th Congress

Item 7 of 7

PREVIOUS BILL | NEXT BILL
PREVIOUS BILL:ALL | NEXT BILL:ALL
NEW SEARCH | HOME | HELP

H.R.1200
SPONSOR: **Rep McDermott, Jim** (introduced 03/18/99)

Jump to: Titles, Status, Committees, Amendments, Cosponsors, Summary

TITLE(S):

- SHORT TITLE(S) AS INTRODUCED:
  American Health Security Act of 1999

- OFFICIAL TITLE AS INTRODUCED:
  A bill to provide for health care for every American and to control the cost and enhance the quality of the health care system.

STATUS: Floor Actions

NONE

STATUS: Detailed Legislative Status

House Actions

Mar 18, 99:
Referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, Government Reform, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
Apr 9, 99:
Referred to the Subcommittee on Military Personnel.
Mar 18, 99:
Referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, Government Reform, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
Apr 5, 99:
Referred to the Subcommittee on Civil Service.
Mar 18, 99:
Referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, Government Reform, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
Apr 12, 99:
Referred to the Subcommittee on Health and Environment, for a period to be subsequently determined by the Chairman.
Mar 18, 99:
Referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, Government Reform, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

STATUS: Congressional Record Page References

03/18/99 Introductory remarks on Measure (CR E495-496)

COMMITTEE(S):

- COMMITTEE(S) OF REFERRAL:
  House Commerce
  House Ways and Means
  House Government Reform
  House Armed Services

- SUBCOMMITTEE(S):
  Hsc Health and the Environment
  Hsc Civil Service
  Hsc Military Personnel

AMENDMENT(S):

NONE

COSPONSORS(18):

Rep Conyers, John, Jr. - 03/18/99	Rep Sanders, Bernard - 03/18/99
Rep Nadler, Jerrold - 03/18/99	Rep Hinchey, Maurice D. - 03/18/99
Rep Serrano, Jose E. - 03/18/99	Rep Fattah, Chaka - 03/18/99
Rep Olver, John W. - 03/18/99	Rep Coyne, William J. - 03/18/99
Rep Frank, Barney - 04/21/99	Rep Pelosi, Nancy - 04/21/99
Rep Miller, George - 04/21/99	Rep Lee, Barbara - 04/21/99
Rep Schakowsky, Janice D. - 04/21/99	Rep Waxman, Henry A. - 04/21/99
Rep Tierney, John F. - 04/21/99	Rep Stark, Fortney Pete - 04/21/99
Rep Baldwin, Tammy - 04/21/99	Rep Owens, Major R. - 06/16/99

SUMMARY:

(AS INTRODUCED)

TABLE OF CONTENTS:

- Subtitle A: Budgeting and Payments to States
- Subtitle B: Payments by States to Providers
- Subtitle C: Mandatory Assignment and Administrative Provisions
- Title VII: Promotion of Primary Health Care; Development of Health Service Capacity; Programs to Assist the Medically Underserved
- Subtitle A: Promotion and Expansion of Primary Care Professional Training
- Subtitle B: Direct Health Care Delivery
- Subtitle C: Primary Care and Outcomes Research
- Subtitle D: School-Related Health Services
- Title VIII: Financing Provisions; American Health Security Trust Fund
- Subtitle A: American health Security Trust Fund
- Subtitle B: Taxes Based on Income and Wages
- Subtitle C: Increase in Excise Taxes on Tobacco Products
- Title IX: Conforming Amendments to the employee Retirement Income Security Act of 1974
- Title X: Additional Conforming Amendments

American Health Security Act of 1999 - **Title I: Establishment of a State-Based American Health Security Program; Universal Entitlement; Enrollment** - Establishes the American Health Security Program (AHSP), to be administered by the States. Requires a State to establish a State health security program (program) to receive Federal health care funding.

(Sec. 102) Entitles every individual who is a U.S. resident and is a U.S. citizen or national or a lawful resident alien to benefits.

(Sec. 103) Requires each State program to provide an enrollment mechanism and issue a health security card to each enrollee.

(Sec. 104) Makes benefits portable. Prohibits a minimum residence or waiting period in excess of a specified period. Allows reciprocal arrangements for coverage of border region enrollees.

(Sec. 106) Supersedes titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act, the Federal Employee Health Benefits Program, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Title II: Comprehensive Benefits, Including Preventive Benefits and Benefits for Long Term Care - Entitles all eligible individuals to payment items and services specified by the American Health Security Standards Board (Board) (established by title IV of this Act).

Prohibits: (1) deductibles, coinsurance, or copayments for acute care and preventive benefits, subject to exception; (2) providers from charging a patient for covered services; and (3) duplicative private insurance.

(Sec. 203) Covers a percentage of home and community-based long-term care services.

(Sec. 204) Sets forth special delivery requirements for mental health and substance abuse treatment services provided to at-risk children. Directs the Board to make national determinations on coverage

of experimental services.

Title III: Provider Participation - Requires providers, to receive payment, to agree: (1) not to discriminate based on race, national origin, income, religion, age, sex or sexual orientation, disability, handicapping condition, or (subject to the qualifications of the provider) illness; (2) not to charge patients for covered services; (3) to furnish necessary information to the Board or program; (4) not to employ excluded providers; and (5) to submit bills within a specified time.

(Sec. 302) Considers a health care provider to be qualified if the provider is licensed or certified and meets State law requirements, Federal requirements, and additional standards specified by the Board. Requires: (1) establishment of national minimum quality assurance standards and related monitoring; and (2) an exchange of information among programs regarding quality assurance and cost containment.

(Sec. 303) Defines a "comprehensive health service organization" (CHSO) as a public or private organization that, in return for a capitated payment, furnishes or arranges for a full range of health services and out-of-area coverage for urgently needed services. Regulates CHSOs.

(Sec. 304) Extends current Medicare prohibitions on physician self-referrals and applies the prohibitions to AHSP.

Title IV: Administration - Subtitle A: General Administrative Provisions - Establishes the American Health Security Standards Board to develop policies and procedures for enrollment, benefits, provider participation, national and State funding levels, assisting programs with planning for capital expenditures and service delivery, and other functions. Mandates uniform reporting standards.

(Sec. 402) Mandates an American Health Security Advisory Council.

(Sec. 404) Requires: (1) each State to submit a plan for a program for providing health care services to residents; (2) the Board to provide States incentives to develop regional planning mechanisms; (3) State programs to meet Federal standards; and (4) each State to appoint a State Health Security Advisory Council.

Allows: (1) programs not meeting Federal requirements to be placed in receivership; and (2) States to use fiscal agents to process CLAIMS.

Subtitle B: Control Over Fraud and Abuse - Authorizes provider exclusion, civil monetary penalties, and criminal prosecution for fraud or abuse, based on current Medicaid standards.

(Sec. 412) Requires each program to establish and maintain a health care fraud and abuse unit.

Title V: Quality Assessment - Establishes the American Health Security Quality Council.

(Sec. 502) Mandates: (1) methods for profiling practice patterns and for identifying those with quality deficiencies; (2) guidelines for procedures performed only at tertiary centers; and (3) standards for education and sanctions regarding those with quality deficiencies.

(Sec. 503) Requires each participating State to establish an entity to conduct quality reviews.

(Sec. 504) Expresses the intent to replace random utilization controls with a systematic review of patterns of practice. Supersedes all existing Federal utilization review programs.

Title VI: Health Security Budget; Payments; Cost Containment Measures - Subtitle A:

Budgeting and Payments to States - Directs the Board to establish a national health security budget specifying the total expenditures to be made by the Federal Government and the States for covered health care services.

(Sec. 602) Provides for the allocation of funds in the budget by the Board to the States.

(Sec. 604) Provides for programs to receive Federal funds equal to a weighted average of a specified percentage of their population-based share of the budget.

(Sec. 605) Requires each program to establish a separate budget account for health professional education expenditures.

Subtitle B: Payments by States to Providers - Directs that: (1) payment for operating expenses for institutional and facility-based care under State programs be made directly to each institution or facility; and (2) facility budgets be adjusted to reflect payments made by CHSOs. Allows programs to permit institutions and facilities to raise funds from private sources for specified purposes.

(Sec. 612) Requires: (1) State programs to pay individual practitioners on a fee-for-service basis; and (2) the Board to establish models for such payment and for global fee payment methodologies. Permits States to require electronic billing.

(Sec. 613) Authorizes programs to pay CHSOs based on annual budgets or risk-adjusted capitation payments, reduced by the costs of covered services not provided by the CHSO.

(Sec. 614) Directs that programs pay for community-based primary health services based on global budgets, basic primary care capitation amounts for enrollees, or fee-for-service.

(Sec. 615) Requires: (1) the Board to establish a list of approved prescription drugs and to determine maximum prices; and (2) each program to pay for such drugs based on such maximum prices and to pay separate dispensing fees to pharmacies.

(Sec. 616) Directs: (1) the Board to establish a list of approved durable medical equipment and therapeutic devices and equipment; and (2) programs to pay for such items based on maximum prices determined by the Board.

(Sec. 617) Requires State programs to pay for other items and services based on methodologies adopted by the Board.

(Sec. 618) Directs the Board to establish model payment methodologies and other incentives that promote the provision of services in medically underserved areas.

(Sec. 619) Authorizes programs to use alternative payment methodologies, provided certain requirements are met.

Subtitle C: Mandatory Assignment and Administrative Provisions - Requires that participating providers accept program payment as full payment. Permits provider exclusion and civil penalties for violations.

(Sec. 632) Requires a provider payment appeals process.

Title VII: Promotion of Primary Health Care; Development of Health Service Capacity; Programs to Assist the Medically Underserved - Subtitle A: Promotion and Expansion of Primary Care Professional Training - Sets forth Board responsibilities regarding the education of health professionals.

Sets as national goals that: (1) at least 50 percent of graduate medical residencies be in primary care within five years of this Act's enactment; and (2) there be a certain number, specified by the Board, of midlevel primary care practitioners employed in the health care system by a specified date.

(Sec. 702) Mandates an Advisory Committee on Health Professional Education.

(Sec. 703) Requires transfer of specified revenues from the American Health Security Trust Fund (Fund) for certain existing programs supporting health professional education and nursing education and for the National Health Service Corps.

Subtitle B: Direct Health Care Delivery - Mandates transfer of specified Fund revenues to the Public Health Service for maternal and child health block grants, prevention and treatment of tuberculosis, prevention and treatment of sexually transmitted diseases, preventive health block grants, grants to States for community mental health services and the prevention and treatment of substance abuse, grants for HIV health care services, public health formula grants, and primary care service expansion grants.

(Sec. 713) Mandates grants to primary care centers to plan, develop, and deliver primary care to medically underserved populations.

Subtitle C: Primary Care and Outcomes Research - Mandates transfer of specified Fund revenues to the Agency for Health Care Policy and Research for health outcomes research.

(Sec. 722) Amends the Public Health Service Act to establish in the National Institutes of Health an Office of Primary Care and Prevention Research and a national data system and clearinghouse on primary care and prevention research. Authorizes appropriations.

Subtitle D: School-Related Health Services - Authorizes appropriations for this subtitle. Mandates grants to State health agencies or to local community partnerships to develop and operate school health service sites.

Title VIII: Financing Provisions; American Health Security Trust Fund - Subtitle A: American Health Security Trust Fund - Amends the Internal Revenue Code to create the American Health Security Trust Fund (Fund). Appropriates to the Fund the increase in tax liabilities attributable to the application of amendments made by this title and receipts from: Medicare, Medicaid, Federal employees' health benefits program, CHAMPUS, Maternal and Child Health program (under title V of the Social Security Act), vocational rehabilitation programs, drug abuse and mental health services programs under the Public Health Service Act, programs providing general hospital or MEDICAL assistance, and certain other Federal programs. Transfers to the Fund amounts in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

Subtitle B: Taxes Based on Income and Wages - Imposes a health care excise tax on every employer and on the self-employed, railroad employers, and railroad employee representatives.

Imposes an individual health care income tax. Prohibits credits against the tax and any effect on the minimum tax in relation to the individual health care income tax.

Subtitle C: Increase in Excise Taxes on Tobacco Products - Increases the excise taxes on tobacco products.

Title IX: Conforming Amendments to the Employee Retirement Income Security Act of 1974 - Makes the Employee Retirement Income Security Act of 1974 (ERISA) inapplicable to health coverage arrangements under State health security programs. Exempts State health security programs

from ERISA preemption. Prohibits employee benefits duplicating State health security program benefits and requires that a liable workers' compensation carrier reimburse the State health security plan. Repeals ERISA continuation coverage requirements.

Title X: Additional Conforming Amendments - Repeals specified provisions of the Health Insurance Portability and Accountability Act, ERISA, and the Public Health Service Act.

Bill Summary & Status for the 106th Congress

Item 6 of 7

PREVIOUS BILL | NEXT BILL
PREVIOUS BILL:ALL | NEXT BILL:ALL
NEW SEARCH | HOME | HELP

H.R.1819
SPONSOR: **Rep McDermott**, Jim (introduced 05/14/99)

Jump to: Titles, Status, Committees, Amendments, Cosponsors, Summary

TITLE(S):

- SHORT TITLE(S) AS INTRODUCED:
  Working Uninsured Tax Equity Act of 1999

- OFFICIAL TITLE AS INTRODUCED:
  A bill to amend the Internal Revenue Code of 1986 to allow individuals who are not eligible to participate in employer-subsidized health plans a refundable credit for their health insurance costs.

STATUS: Floor Actions

NONE

STATUS: Detailed Legislative Status

House Actions

May 14, 99:
Referred to the House Committee on Ways and Means.

STATUS: Congressional Record Page References

05/14/99 Introductory remarks on Measure (CR E972-974)

COMMITTEE(S):

- COMMITTEE(S) OF REFERRAL:
  House Ways and Means

AMENDMENT(S):

NONE

COSPONSORS(17):

Rep Rogan, James E. - 05/14/99
Rep Stark, Fortney Pete - 05/14/99
Rep Graham, Lindsey O. - 05/14/99
Rep Matsui, Robert T. - 05/14/99
Rep Lewis, John - 05/14/99
Rep Neal, Richard E. - 05/14/99
Rep Thurman, Karen L. - 05/14/99
Rep Emerson, Jo Ann - 05/14/99
Rep Kilpatrick, Carolyn C. - 05/14/99
Rep Frost, Martin - 05/14/99
Rep Inslee, Jay - 05/14/99
Rep Shows, Ronnie - 05/14/99
Rep McHugh, John M. - 05/14/99
Rep Pelosi, Nancy - 05/14/99
Rep Sandlin, Max - 05/19/99
Rep Berkley, Shelley - 05/19/99
Rep Hinchey, Maurice D. - 06/08/99

SUMMARY:

(AS INTRODUCED)

Working Uninsured Tax Equity Act of 1999 - Amends the Internal Revenue Code to allow an individual a refundable tax credit equal to 30 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents. Disallows such a credit for: (1) any taxpayer eligible to participate in his or her employer's (or spouse's employer's) subsidized health plan; or (2) Medicare or Medicare supplemental policy payments.

Limits the full credit to individuals whose adjusted gross income is under $30,000 ($50,000 if filing a joint return). Disallows any credit to a married individual filing a separate return, but treats married individuals living apart and filing separate returns as not married (thus qualifying them for the credit). Prescribes a formula for phase-out of the credit for taxpayers with an adjusted gross income exceeding $30,000 ($50,000 for a joint return) by less than $10,000.

Allows self-employed individuals to elect such credit or the deduction for medical expenses, but not both.

States that such credit does not apply to long-term health care insurance.

HR 1819 IH

106th CONGRESS

1st Session

H. R. 1819

To amend the Internal Revenue Code of 1986 to allow individuals who are not eligible to participate in employer-subsidized health plans a refundable credit for their health insurance costs.

IN THE HOUSE OF REPRESENTATIVES

May 14, 1999

Mr. MCDERMOTT (for himself, Mr. ROGAN, Mr. STARK, Mr. GRAHAM, Mr. MATSUI, Mr. LEWIS of Georgia, Mr. NEAL of Massachusetts, Mrs. THURMAN, Mrs. EMERSON, Ms. KILPATRICK, Mr. FROST, Mr. INSLEE, Mr. SHOWS, Mr. MCHUGH, and Ms. PELOSI) introduced the following bill; which was referred to the Committee on Ways and Means

---

A BILL

To amend the Internal Revenue Code of 1986 to allow individuals who are not eligible to participate in employer-subsidized health plans a refundable credit for their health insurance costs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Working Uninsured Tax Equity Act of 1999'.

SEC. 2. REFUNDABLE CREDIT FOR HEALTH INSURANCE COSTS.

(a) IN GENERAL- Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable personal credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

`SEC. 35. HEALTH INSURANCE COSTS.

`(a) IN GENERAL- In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to 30 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

`(b) LIMITATIONS-

`(1) LIMITATION BASED ON EARNED INCOME- The payments taken into account under subsection (a) for any taxable year shall not exceed the sum of--

`(A) the taxpayer's wages, salaries, tips, and other employee compensation includible in gross income, plus

`(B) the taxpayer's earned income (as defined in section 401(c)(2)).

`(2) LIMITATION BASED ON OTHER COVERAGE- Subsection (a) shall not apply to--

`(A) any taxpayer for any calendar month for which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer, or

`(B) amounts paid for coverage under--

`(i) part B of title XVIII of the Social Security Act, or

`(ii) a Medicare supplemental policy (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) or similar supplemental coverage provided under a group health plan.

The rule of the last sentence of section 162(l)(2)(B) shall apply for purposes of subparagraph (A).

`(c) LIMITATION BASED ON ADJUSTED GROSS INCOME-

`(1) IN GENERAL- No credit shall be allowed under subsection (a) for any taxable year for which the taxpayer's adjusted gross income exceeds the applicable dollar amount by $10,000 or more.

`(2) PHASEOUT- If the taxpayer's adjusted gross income for the taxable year exceeds the applicable dollar amount by less than $10,000, the credit which would (but for this subsection and subsection (d)) be allowed under subsection (a) shall be reduced (but not below zero) by an amount which bears the same ratio to such credit as such excess bears to $10,000. Any reduction under the preceding sentence which is not a multiple of $10 shall be rounded to the next lowest $10.

`(3) APPLICABLE DOLLAR AMOUNT- The term `applicable dollar amount' means--

`(A) in the case of a taxpayer filing a joint return, $50,000,

`(B) in the case of any other taxpayer (other than a married individual filing a separate return), $30,000, and

`(C) in the case of a married individual filing a separate return, zero.

`(4) SPECIAL RULE FOR MARRIED INDIVIDUALS FILING SEPARATELY AND LIVING APART- A husband and wife who--

`(A) file separate returns for any taxable year, and

`(B) live apart at all times during such taxable year,

shall not be treated as married individuals for purposes of this paragraph.

`(d) LIMITATION BASED ON AMOUNT OF TAX-

`(1) IN GENERAL- The credit allowed by subsection (a) for the taxable year (determined after the application of subsections (b) and (c)) shall not exceed the sum of--

`(A) the tax imposed by this chapter for the taxable year (reduced by the credits allowable against such tax other than the credits allowable under this subpart), and

`(B) the taxpayer's social security taxes for such taxable year.

`(2) SOCIAL SECURITY TAXES- For purposes of paragraph (1)--

`(A) IN GENERAL- The term `social security taxes' means, with respect to any taxpayer for any taxable year--

`(i) the amount of the taxes imposed by sections 3101, 3111, 3201(a), and 3221(a) on amounts received by the taxpayer during the calendar year in which the taxable year begins,

`(ii) the taxes imposed by section 1401 on the self-employment income of the taxpayer for the taxable year, and

`(iii) the taxes imposed by section 3211(a)(1) on amounts received by the taxpayer during the calendar year in which the taxable year begins.

`(B) COORDINATION WITH SPECIAL REFUND OF SOCIAL SECURITY TAXES- The term `social security taxes' shall not include any taxes to the extent the taxpayer is entitled to a special refund of such taxes under section 6413(c).

`(C) SPECIAL RULE- Any amounts paid pursuant to an agreement under section 3121(l) (relating to agreements entered into by American employers with respect to foreign affiliates) which are equivalent to the taxes referred to in subparagraph (A)(i) shall be treated as taxes referred to in such subparagraph.

`(e) COORDINATION WITH OTHER PROVISIONS-

`(1) DEDUCTION FOR MEDICAL EXPENSES- The amount taken into account in computing the credit under subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

`(2) SELF-EMPLOYED INDIVIDUALS ALLOWED EITHER DEDUCTION OR CREDIT FOR HEALTH INSURANCE- No credit shall be allowed under this section to a taxpayer for a taxable year if any amount is allowed as a deduction to such taxpayer for such year under section 162(l).

`(f) EXPENSES MUST BE SUBSTANTIATED- A payment for insurance to which subsection (a) applies may be taken into account under this section only if the taxpayer substantiates such payment in such form as the Secretary may prescribe.

`(g) SECTION NOT TO APPLY TO LONG-TERM CARE INSURANCE- This section shall not apply to insurance which constitutes medical care by reason of section 213(d)(1)(C).'

(b) CLERICAL AMENDMENT- The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

`Sec. 35. Health insurance costs.

`Sec. 36. Overpayments of tax.'

(c) EFFECTIVE DATE- The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

END

Congressman
Jim McDermott
7th District, Washington

SHORT SUMMARY OF THE AMERICAN HEALTH SECURITY ACT OF 1999

The American Health Security Act embodies the characteristics of a truly American bill. It will give to all Americans the peace of mind -- the security -- to which all citizens should be entitled. It creates a system of health care delivered by physicians chosen by the patient. No one will have to leave their existing relationships with their doctors or hospitals or other providers. It is federally financed but administered at the state level, so the system is highly decentralized. And it provides new mechanisms to improve the quality of care every American receives.

The American Health Security Act (the Bill) provides universal health insurance coverage for all Americans as of January 1, 2001. It severs the link between employment and insurance. The federal government defines the standard benefit package, collects the premium, and distributes the premium funds to the states. The states, through negotiating panels comprised of representatives from business, labor, consumers and the state government, negotiate fees with the providers and the government controls the rate of price increases. The result is health care coverage that never changes when your personal situation does, never requires you to change the way you seek health care, and never causes disruptions in your relationships with your providers.

The Bill provides the coverage under a mechanism of global budgets to achieve controllable and measurable cost containment that will yield scorable savings over the next five years. Unlike other single-payer proposals of the past, it provides for almost exclusive state administration provided the states meet federal budget, benefit package, guarantee of free choice of provider, and quality assurance standards. This bill explicitly preserves free choice of provider by providing a mechanism for fee-for-service delivery to compete effectively with HMOs. It will not force Americans into HMO models.

The insurance mechanism of the American Health Security Act is easy to use and understand. Quite simply, a patient visits the doctor or other provider. The provider then bills the state for the services provided under the standard benefit package and the state pays the bill on the patient's behalf, just as insurance companies pay medical bills on the patient's behalf now. The difference is that complicated and expensive formulas for patient co-payments, coinsurance, and deductibles in addition to premium costs are eliminated.

The standard benefit package is in fact extremely generous. It covers all inpatient and outpatient medical services without limits on duration or intensity except as delineated by outcomes research and practice guidelines based on quality standards. It provides for coverage of comprehensive long-term care, dental services, mental health services and prescription drugs. Cosmetic procedures and other "frill" benefits such as private rooms and comfort items are not covered.

The extent of state discretion is substantial. The federal budget is divided into quality assurance, administrative, operating, and medical education components. The system is financed 86% by the federal government and 14% by the states. That federal pie is then apportioned among the states. For example, states with large elderly populations can be expected to require a larger volume of higher intensity services and will receive a larger federal contribution. However, the states are free to determine how that money is allocated among types of providers and to negotiate those allocations according to the state's individual needs, provided federal standards are met. The ability of HMOs to operate and compete on a capitated basis is preserved.

The states must demonstrate the efficacy of their methodologies or federal models will be imposed.

However, states are not required to seek waivers in advance. While the federal government will not make separate allocations to states for capital and operating budgets, the states are free to allocate capital separately to assure adequate distribution of resources throughout the state and to develop their own mechanisms for doing so.

The financing package reflects the CBO scoring of this bill's predecessor, H.R. 1200, in the **103rd Congress**. The numbers were provided by the Joint Committee on Taxation (JCT) on the basis of the CBO scoring. Accordingly, the Bill is fully financed. In fact, JCT estimates that the American Health Security Act will lead to deficit reduction approximating $100 billion per year by the year 2004.

Everyone will contribute to the health insurance system, except the very poor. Employers will pay 8.7% of payroll and individuals will pay 2.2% of their taxable income. A tobacco tax equal to $0.45 per cigarette pack is also imposed. These payroll deductions are lower than current insurance costs for most businesses and individuals, even while providing universal coverage and a more generous benefit package than exists in the private market today. The key is that the money necessary to provide coverage to people who cannot afford it comes from the administrative savings achieved through the elimination of the insurance company middle man. Americans are freed from the hassle of obtaining and keeping their insurance and have a federal guarantee that their health care costs will be paid for, regardless of who their employer is, where they move, or how their personal or family situation changes.

In addition to providing realistic and affordable financing, the Bill provides quality assurance mechanisms that enhance system-wide quality and truly protect the consumer. It attempts to end the interference between doctor and patient. It establishes a system of profiling practice patterns to identify outliers on a systematic basis. Pre-certification of procedures and hospitalization (getting permission from insurers before your doctor can treat you) is prohibited except for case management of catastrophic cases.

Practice guidelines and outcomes research are emphasized as the main quality and utilization control mechanisms which gives physicians latitude to deviate from cookbook medicine where required for individual cases without going through intermediaries. Only if practitioners consistently deviate are they subject to review to ascertain the basis for the pattern of practice. This system includes mechanisms for education and sanctions including case-by-case monitoring when the review indicates serious quality problems with a specific provider.

The need for a 1:1 ratio of primary care physicians to specialists is explicitly set forth. Federal funding to graduate medical education is tied to achieving this ratio. Funding to the National Health Service is also provided to achieve this goal.

Special grants are provided to meet the needs of under served areas through enhanced funding to the community health centers, both rural and urban, to enable outreach and other social support mechanisms. In addition, states have discretion to make special payment arrangements to such facilities to improve local access to care. It is anticipated that the revenue streams established for the public health service, community health centers, and education of primary care providers will double the primary care capacity of rural and other under served areas in this country.

In summary, the American Health Security Act will provide all the citizens with the health care they need at a price both they and their country can afford. It is clear that we cannot afford the price of doing nothing.

Congressman
Jim McDermott
7th District, Washington

Medical Privacy

This bill will protect the privacy of the health records of people across the country. Currently, privacy protections are weak and vary widely from state to state. Only 28 states allow people to even examine their own medical records. This lack of national standards allows employers, schools, marketing agencies and others to obtain access to what ought to be confidential files. This bill will ensure that the information people tell their health care providers is not disclosed to other people without their consent. These guarantees are particularly important as new technologies affect our health care system. New biological technologies, like genetic testing, disclose not just our current health, but our potential future health and the health of our families. Our health information is increasingly becoming computerized, which presents new threats to privacy. Ensuring privacy in medical care is more important now than ever before.

A recent report by scientists at Harvard and Stanford documented 200 cases of people being denied, jobs, insurance, the right to adopt children, educational opportunities, or participation in the armed services because they either had or were suspected to have a genetic predisposition for a disease. The people in these cases were healthy and perhaps would never develop that particular disease.

Bill Summary

This Act protects the privacy of all health information. An important feature of the bill is that it defines protected health information to include genetic information. Genetic information is included under the definitions
of protected health information and health care, in order to ensure that it is given the privacy protections that we grant to general health information. Genetic information is defined broadly so that family histories, and information derived from blood samples and all other sources are fully protected.

Title I: Individual's Rights

Subtitle A allows the review of protected health information by the subjects of the information. It provides guidelines for the inspection, copying, correction, and amendment of protected health information. In addition it requires health information trustees to provide people with notice of their rights, and with information on how the trustee handles health information.

Subtitle B establishes safeguards for the privacy of health information. It includes standards for the security of protected health information that is created, used, maintained or transmitted in electronic or computerized form. These include controls of the access to the information both inside and outside health information trustees, authentication of the identity of persons requesting access to protected health information, procedures to prevent the interception of protected health information transferred by electronic means, and audit trails to keep track of access or attempted access to protected health information. This subtitle also provides for the accounting of disclosures of protected health information, and prohibits retaliation against those who follow this Act.

Title II: Restrictions on Use and Disclosure

Sets out general rules that follow the basic principles that an individual has a right to privacy of their health information, that this right must not be waived in the absence of meaningful notice and informed consent, and that in the absence of an expressed waiver, the right to privacy cannot be eliminated except in a few specific cases described in this Act. This title denotes the types of written authorizations that are needed for different types of disclosures. First, there are authorizations for treatment and payment. Next, there are authorizations for other purposes. In both types of authorizations, the patient is informed of

what information is to be disclosed, for what purpose, to which entity, and for what period of time. The Secretary of HHS will develop model authorizations for this purpose.

The second half of Title II deals with limited circumstances where an individual's health information will need to be disclosed without written consent. In each of these sections, care is taken to guarantee that the reason for the disclosure is sufficiently important that it is justifiable to disclose the information without consent. Second, it is encouraged that coded health information, (which is anonymous, but could be linked to protected health information by authorized persons) or nonidentifiable information, (which is anonymous and cannot be linked to anyone) is used instead of identifiable protected health information. The cases where identifiable information is disclosed without authorization are for specific cases of: emergency circumstances, health oversight purposes, accreditation, public health reporting, and certain law enforcement situations.

Title III. Sanctions.

The Act includes a private right of action, as well as civil and criminal sanctions, to strongly discourage violations of the Act.

Title IV. Miscellaneous.

An Advisory Group will advise the Secretary of HHS on the regulations needed to implement this Act. The Group will include consumers, health care providers, health plans, privacy experts, and computer security experts.

This bill does not pre-empt State law. It sets up a federal minimum standard for the protection of the privacy of health information. This is similar to what was done with the Americans with Disabilities Act.

INTRODUCTION OF THE WORKING UNINSURED TAX EQUITY ACT -- HON. JIM MCDERMOTT (Extension of Remarks - May 14, 1999)

[Page: E972]

HON. JIM MCDERMOTT

in the House of Representatives

FRIDAY, MAY 14, 1999

- Mr. McDERMOTT. Mr. Speaker, today I rise to share with you some ideas that both Representative **Rogan** and I have about how to begin addressing the issue of the uninsured.

- Many of us are stymied by the health care paradox of a booming economy. Our economy is booming. Unfortunately, parallel to this economic growth is the growing number of uninsured. There are now almost 44 million uninsured people in this country--an increase of more than 5 million since 1993.

- Today, we are introducing legislation to help stop the increase by targeting a 30% health insurance tax credit to the working uninsured. To qualify for our partially refundable credit, taxpayers must not currently be offered health insurance through their employer and they must have an individual income below $30,000/yr or a joint income of less than $50,000/yr. To ease administration, these income limits have been designed to match those of traditional IRAs.

- When the General Accounting Office evaluated a similar proposal last June, it found that almost 36 million individuals without employer-based coverage--roughly 75% of the uninsured--would be eligible for the full credit on the basis of their adjusted gross income. Additionally, under our proposal, the self-employed would have the opportunity to choose between our proposed credit or the 60% deduction allowed by current law.

- The benefits of this proposal are not only that it provides a tax benefit for those who need it most, it also would encourage health care consumers to be cost-conscious when choosing their health insurance loans so that they could maximize the value of the credit.

- As you consider our proposal, keep in mind three questions: (1) who the uninsured are, (2) how has the tax code impacted health insurance in this country, and (3) most importantly, what can the 106th Congress realistically do to address this important social policy issue.

- First, who are the uninsured? Contrary to what many people might think, roughly 75% of the uninsured work full or part-time. The remaining 25% are split evenly between those who are unemployed and those who are not in the labor force.

- There isn't enough time today to talk at length about the demographics of the working uninsured. If we did, we'd find that most of them are age 18-34, that a disproportionate number of them are minority, that working poor parents are twice as likely to be uninsured as poor parents who are unemployed, and that the highest rate of uninsurance impacts pre-seniors between the age of 62-64.

- Second, how has the tax code impacted health insurance in this country? Since WW II, America has relied on employers to provide health insurance and has rewarded them accordingly through the tax code. But, a growing number of workers lack employer-based insurance which policy-makers once took for granted.

- Let me give a practical example of how the working uninsured fall through the cracks of our current employer based system. It you make $6.50 an hour your after tax income is $11,500. If you tried to purchase an average health insurance plan it would cost you about $3000. It is obvious that if the working poor are going to get health insurance we are going to have to come up with a way to help them.

- I think we should all find it unacceptable for a person who works full time in this country not to be able to afford health insurance.

- Third question, how do we in the 106th Congress address the issue of the working uninsured?

- As you all know, I am a strong believer in universal health insurance and that the most efficient way of providing it is through a single payer financing system. A system that would lift the prohibitive burden of health insurance administration from employers and replace it with a public premium that shares responsibility throughout society.

- But, if there is a way for us to guarantee universal coverage without single payer--through a plan based on tax credits, Clinton-care, or Medicare for all--I am willing to look at the proposal, as long as the plan guarantees access to quality care that's affordable. My bottom line is quality care at an affordable price.

- Unfortunately, just because something is efficient--such as a single payer system--doesn't always mean that it will pass anytime soon. The reality is that the political climate to have an honest debate about universal coverage was destroyed by partisan bickering in 1994.

- As a policymaker, the next question for me then becomes, what can we do in the near term to help folks who need health insurance today.

- The tax code is a good place to look. After all it is the foundation of our employer-based health insurance system.

- For a number of years now, this issue for me has been about simple tax fairness. As many may know, Congress recently made matters worse by passing legislation to allow the self-employed to deduct 100 percent of the cost of health insurance from their taxes. Since 1995, I have attempted to equalize the tax treatment of health insurance benefits by offering amendments on the House floor and in the Ways and Means Committee, and by introducing H.R. 539 in the last Congress.

- My rallying cry--which I am glad to see is starting to take hold--has been the rhetorical question: Why should a doctor or attorney who is self-employed be able to deduct a portion of the cost of his/her health insurance, while a secretary, who must buy his/her own health

- insurance policy, not be able to deduct one cent of the cost!

- So as a simple matter of fairness, this inequity in the tax code needs to be fixed.

- According to the DC-based Lewin Group, the average federal health benefits tax expenditure is $918 per family. That sounds pretty good until you realize that a family whose income is below $40,000 receives an average of $766 in tax benefits, a $30,000 family receives just $500 in tax subsidies--and the numbers get more depressing if I continue down the income scale.

- The bulk of the tax subsidy is going to those who need it the least. If you make $100,000 or more, the tax code subsidizes your health insurance each year by more than $2,000.

- So it seems to me that if Congress wanted to address the issue of tax fairness and assist a group of people who are in most need of health insurance, it would look at our proposal for a 30% credit. Our proposal is a reasonable and prudent approach to helping people who the system has forgotten about.

- We are initiating the debate with a less is more approach. Our legislation will be less than 6 pages long.
- I am hopeful that the sudden interest in tax code equalization will allow for thoughtful discussions and critiques of the wide range of proposals that will be offered this year.
- In particular, as policymakers put forward proposals, they need to consider what the `take up rate' will be (will people use the credit if they are eligible), how does it impact existing employer health care contributions, and how much does the proposal cost.
- I don't want to leave you with the impression that our limited proposal is the ultimate answer. I view it as a first step toward finding a solution for the uninsured.
- I am proud of the fact that it is a moderate proposal because there are so many uncertainties about how it would work.
- For example, we completely avoid the issue of market reforms because going down that route creates more divisions among political parties that can be realistically addressed in this Congress. By gently impacting the individual marketplace, I am hopeful that state legislatures will take steps to rationalize their individual markets and Congress can learn from both their successes and mistakes.
- Conversely, more costly proposals that hope to dramatically influence the marketplace must include meaningful market reforms. Otherwise, such proposals will just be throwing large amounts of federal tax expenditures at an individual marketplace that is already overpriced. But there is no consensus around market reforms to be found.
- I would also be especially cautious about more ambitious tax credit proposals because they run into serious financing problems. How do you pay for it without running a deficit? Even in this era of expected budget surpluses, a hefty price tag simply is prohibitive given our other national policy priorities.
- More importantly, current comprehensive tax credit proposals may not be such a good deal for either the insured or the uninsured. If they appear too generous, employers will drop coverage and allow for their existing costs to be replaced with an inadequate government voucher, a voucher that would not come close to equaling their existing coverage.
- Letting employers off the hook while increasing government and beneficiary costs would make the problem worse.
- I am the first one to say that our credit should not replace the current system. If it did, it would be inadequate. That is not to say, however, that most of us in this room would not like to see the current system totally overhauled.
- I view our proposal as a targeted effort to stop the current health insurance hemorrhaging, to induce some additional people to purchase health insurance before they get sick, as an achievable goal in a very divided Congress, and a stimulant of the necessary discussion we need to have about how this country can create an efficient means of providing universal health care coverage.
- Chairman **Archer** has said he would like to mark-up tax legislation later this spring. **Jim** and I already have written him and Mr. **Thomas** asking them to look closely at our proposal for its immediate benefits. We have also asked the White House to look at our proposal and I hope that they too will once again show leadership by joining us in attempting to tackle this difficult issue of the uninsured.
- By bringing people together, I am confident that we can build momentum within the Congress to

generate bipartisan support behind proposals that begin to address the needs of the uninsured. Passage of our credit would be a first step toward enlightening that discussion.

- I urge my colleagues to join us in our bipartisan effort.

[Page: E973]

Average Per Family $918:

Less than $15,000

$63

$15,000 to $19,999

288

$20,000 to $29,999

497

$30,000 to $39,999

766

$40,000 to $49,999

1,177

$50,000 to $74,999

1,558

$75,000 to $99,999

1,767

$100,000 or more

2,059

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

[Page: E974]

END

PHOTOCOPY
PRESERVATION

February 12, 1999

Alzheimer's Study Shows Caregivers Need Financial Assistance

Report Underscores Need for Johnson's Legislation

Washington, DC --U.S. Rep. Nancy Johnson joined representatives from the National Alliance for Caregiving and the Alzheimer's Association to release a new study confirming that U.S. families are the backbone of the long-term care system, providing care at enormous personal cost.

"This reports begins to show us how costly Alzheimer's caregiving can be, both financially and emotionally," Johnson said at a Capitol Hill press conference. "Millions of families face the daily challenge of caring for a loved one with Alzheimer's and they need our help."

The report, Who Cares? Families Caring for Persons with Alzheimer's Disease, counts at least five million American households tending to loved ones with Alzheimer's. It also found that Alzheimer caregivers suffer higher levels of physical strain and emotional stress in addition to the tremendous financial burden.

"These results are sounding an alarm that something must be done to assist those who undertake the emotional and financial strain that comes with caring for those with long-term illnesses," Johnson said. "We must provide greater financial security against the tremendous costs that are associated with long-term care."

Johnson will introduce legislation within the next month to provide families with some protection against long-term care costs. Titled the "Long-Term Care and Retirement Security Act," her bill would create a tax credit for the purchase of long-term care insurance as a low-cost means of helping families cope with the high expenses associated with this form of health care. Nursing home costs for long-term care patients costs roughly $40,000 a year per person.

"Very few people can now deduct long-term care premiums," Johnson added. "My legislation would also provide a tax credit to give families caring for someone with Alzheimer's needed financial assistance."

The report further outlined that the current crisis in caregiving will only get worse. The 78 million Americans born in the baby boom years of 1946 through 1964 make up 29 percent of the nation. This aging of the population means an Alzheimer's epidemic is looming as an estimated 14 million Americans will have Alzheimer's disease during the next 50 years.

The report was produced by the National Alliance of Caregiving in conjunction with the Alzheimer's Association.

Statement of the Honorable Nancy L. Johnson, M.C., Connecticut

Testimony Before the House Committee on Ways and Means

Hearing on Reducing the Tax Burden: I. Enhancing Retirement and Health Security

June 16, 1999

Thank you for calling this hearing today, Mr. Chairman, and giving me the opportunity to testify on two issues that I care deeply about: health and retirement security. While our tax code provides significant benefits in these areas. We must improve these benefits if we are to reduce the number of uninsured Americans and meet the challenges that we face as the number of elderly Americans doubles.

In 1998, the federal government contributed an estimated $111 billion toward tax benefits aimed at the purchase of health insurance. The vast majority of these tax breaks went to those who held employer-sponsored health insurance. Only $4.3 billion was in the form of tax deductions taken by individuals for out-of-pocket health spending. That leaves $106.7 billion devoted to workers who received health insurance through their employers -- $70.9 billion through the federal income tax and $28.2 billion and $7.8 billion in Social Security and Medicare taxes, respectively. This employer-based tax break equals approximately $1000 for the average family with coverage.

This favorable tax treatment of employer-based health insurance has resulted in the coverage of nearly two-thirds of adults under the age of 65. Through group purchasing, it spreads the risk of insuring people with varying health needs, making insurance costs lower for those who are sicker or older. This makes the value of employer-based health insurance much greater than the wages that any single employee could receive in the absence of the benefit. It also means that the current tax subsidy is more meaningful and worthwhile for those with poor health.

Health benefits are consistently ranked as the most important employee benefit among workers. In a competitive labor market, the promise of health benefits not only makes workers more likely to take a job but also more likely to stay at a job. In addition, employers offering benefits have found that their workers are more productive, through decreased number of sick days, improved worker morale, and increased loyalty.

One of the major faults of the employment-based health insurance system is that many small employers cannot afford to offer health insurance to their workers. Only 28% of employers with less than 25 workers offer health insurance, compared with over 66% of employers with 500 or more employees. The largest reason for small employers not offering health insurance is the higher costs they face. Their small size means they cannot spread the risk associated with a few unhealthy employees. They also face higher administrative costs. A 1998 Hay Huggins coverage survey found that overhead costs for firms with few than 10 employees exceeded 35%, compared with about 12% for firms over 500.

If we are going to address the problem of uninsured Americans, we must help more small employers afford to offer health insurance coverage. People working for small businesses account for 16% of the under-65 population, but 28% of the uninsured. And small businesses provide one of the fastest growing employment opportunities.

The challenge in our voluntary health insurance system is to provide equal benefits for people who do not have access to employer-sponsored coverage. It is important to preserve the current employer-based system because many people prefer getting coverage through their job and employer coverage has been very successful in covering two-thirds of the workforce. As the nature of employment changes, moving to small businesses and temporary and contract work, it is necessary that we also allow an individually based tax benefit for those who are not offered employer-based coverage.

This is not only a matter of equity in the tax code but also a means of addressing the problem of uninsured Americans by making health insurance more affordable. Increasing tax benefits to individuals would by no means solve the uninsured problem, but it would help those who can afford to purchase

health insurance on their own. If we can isolate this category of the uninsured, we will have a better idea of how to approach the remaining uninsured, those who need significant assistance purchasing health insurance or who lack access to health insurance because of their health status. There are many reasons that people do not purchase health insurance, so we need a multi-faceted approach to solve the problem.

I am advocating a combination of tax credits and deductions for people who purchase their own health insurance. According to a Congressional Research analysis of the March 1997 Current Population Survey, 52% of the uninsured fall in the 15% tax bracket. For the majority of the uninsured, a deduction would provide only a 15% discount on the cost of their health insurance. A credit, on the other hand, would provide the same benefit to all taxpayers. And studies have shown that a significant credit is required to encourage people to begin purchasing health insurance. Kenneth Thorpe demonstrated in a 1999 study that a tax credit of $400 would encourage 18% of single uninsured workers with incomes at 150% of the federal poverty level to participate in a health plan. A credit worth double that amount ($800) would raise the participation rate among this group to 22%.

My tax credit proposal, found in H.R. 2020, would offer taxpayers a credit worth 60% of the cost of their health insurance, up to $1200 for individuals and $2400 for couples and families. It would be dedicated to those people who do not have access to an employer-sponsored health plan and have incomes below $40,000 for individuals and $70,000 for couples and families.

My credit would be available for people who purchase individual or COBRA health insurance coverage. Therefore, it would have the benefit of increasing the number of people who purchase COBRA coverage and lower the costs to businesses of providing this coverage. COBRA coverage is costly to businesses because the people who tend to buy it are sicker people who most need the coverage. Making it more affordable, as my tax credit would, has the potential to add more healthy people to the pool of people purchasing COBRA.

Making individual health insurance more affordable would also help stimulate the individual health insurance market. Currently, only 7-9% of individuals purchase coverage on the individual market. My tax credit would create more demand for individual insurance and help stimulate the market to come up with new products. In addition, we may want to consider other health insurance reforms to create broader pooling for individual health policies to make them more affordable and accessible for people with health care needs.

Finally, we should develop a tax credit system that makes the credits available to people during the year, rather than at the end of the tax year. Making the money accessible at the time of purchase would help ensure that people can afford the coverage. The option that I am examining would allow people to increase their income tax withholding to lower the amount of taxes that they pay during the year. It would create a check-off line on the W-2 form to remind people that the option is available. The benefit of this option is that people can change their withholding form at any time during the year, so they could change the withhold when their insured status changes.

My legislation also would create a tax deduction for individuals who pay at least 50% of the cost of their health insurance. The deduction would be available for individuals whose income is too high to qualify for the health credit or who are purchasing group coverage and paying at least 50% of the cost. The deduction would enable small employers to offer health insurance and take advantage of lower costs through pooling, even if they could not contribute a significant portion of the cost, knowing that their employees could take a deduction for the portion of the cost that they contribute.

The potential benefit for credits and deductions decreasing the number of uninsured is significant. The General Accounting Office evaluated a proposal to provide a 30% tax credit and found that nearly 40 million non-elderly individuals would have been eligible in 1996. The GAO study shows that this approach would provide significant assistance to the uninsured -- 31.9 million of the eligible individuals were uninsured and would have received a tax credit. The Congressional Research Service roughly estimated in a 1997 memo that "allowing taxpayers to deduct the full cost of health insurance would increase coverage by about 9% for those with a 15% marginal tax rate (about 1.4 million adults) and 17% for those with a 28% marginal tax rate (about 345,000 adults)." According to CRS, a 100%

deduction would reduce the number of uninsured by 1.75 million. Combining a deduction with a credit would, therefore, reach a significant number of the uninsured.

I also want to talk about the issue of long-term care and the legislation that I have introduced. Long-term care promises to be the most significant health issue of the next century as the Baby Boom generation begins to retire and the number of our elderly doubles. Medicare and Social Security are two of the three government sponsored-programs that are critical to the elderly. The other federal program significantly impacted by the increasing number of elderly is the Medicaid program through its coverage of nursing home care.

In 1997, Medicaid paid nearly 50% of nursing home care -- at a cost of $40 billion. Nursing home care averages $50,000 per year or $136 per day. The Health Care Financing Administration estimates nursing home costs will be $148.3 billion by 2007. If Medicaid continues to pay for a significant amount of long-term care, this will nearly double Medicaid nursing home costs over the next seven years. And this is before the full impact of the Baby Boom retirement. Today's 77 million baby boomers start turning 85 in 2030. If past trends continue, 20% of those over age 85 will need nursing home care.

How do we deal with these staggering costs? We need to encourage people to prepare for the largest threat to their retirement security. If we encourage more people to plan ahead, we can ensure that we target precious Medicaid dollars to those who are truly in need. We began this process in 1996 by passing provisions to give greater tax benefits to long-term care insurance. But many individuals cannot take advantage of these provisions because they do not have health expenses that exceed 7.5% of their adjusted gross income.

Congresswoman Karen Thurman and I have introduced the Long-Term Care and Retirement Security Act of 1999, H.R. 2102, to create individual tax incentives for people to meet their long-term care needs. Our legislation would create an above-the-line tax deduction for people who purchase qualified long-term care insurance policies, as defined by the Health Insurance Portability and Accountability Act of 1996. In effect, people would be able to deduct the cost of their long-term care insurance policy from their taxable income, eliminating the need to meet the 7.5% floor and the requirement to itemize.

H.R. 2102 would also create a $1000 tax credit for caregiving and long-term care services. Family caregivers provide a tremendous amount of long-term care services. Their role goes far beyond comforting a family member struggling with a chronic illness. National studies have demonstrated that caregivers provide services estimated to value over $190 billion annually. Without the assistance of caregivers, more people would require institutional care and the public cost of long-term care services would increase significantly.

The other critical problem in the area of long-term care is that people are not aware of the need to plan ahead. Seventy-nine percent of older baby boomers surveyed believe that long-term care is the greatest risk to their standard of living. Despite this concern, people are misinformed about the necessity of planning ahead. Several national surveys have shown that the majority of people believe that Medicare covers long-term care, but it does not. And people are unaware that Medicaid qualification requires that they become impoverished.

H.R. 2102 would address this dire lack of information by creating an educational campaign within the Social Security Administration targeted toward individuals and employers. The legislation would instruct the Social Security Administration to provide information to people over 50 as part of their existing annual mailing of earnings statements. It would make individuals aware of the shortcomings of Medicare and the requirement that a person impoverish themself to qualify for Medicaid. In addition, it would illustrate the tax benefits associated with purchasing long-term care insurance.

Finally, H.R. 2102 would remove the restrictions placed on states in 1993 and encourage more of them to create long-term care partnership programs. My legislation would allow people who purchase partnership plans to pass along to their children in their estates assets equal to 75% of the value of their partnership plan. State long-term care partnership programs are important because they make long-term care insurance affordable for low and middle-income people. By encouraging more people to purchase

partnership plans, we ensure that people will have some private coverage of their long-term care expenses before qualifying for Medicaid. Connecticut was the first state to form an long-term care partnership, and our experience has been that one-third of the people who purchase the policies say that they would have disposed of their assets to qualify for Medicaid in the absence of a partnership program. As a result, the availability of partnership programs helps ensure that people use private long-term care insurance before applying for the Medicaid program. Most importantly, partnerships are a means to help us avoid some of the Medicaid financing of long-term care expenses, the fastest growing aspect of Medicaid spending.

We need to help Americans protect themselves and their hard-earned retirement savings from the catastrophic costs of long-term care. The Long-Term Care and Retirement Security Act of 1999 would strengthen current law in this area.

HR 2261 IH

HR 2190

106th CONGRESS

1st Session

H. R. 2261

To amend the Internal Revenue Code of 1986 to provide incentives for health coverage.

IN THE HOUSE OF REPRESENTATIVES

June 17, 1999

Mrs. JOHNSON of Connecticut (for herself and Mr. PETERSON of Pennsylvania) introduced the following bill; which was referred to the Committee on Ways and Means

---

A BILL

To amend the Internal Revenue Code of 1986 to provide incentives for health coverage.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Health Insurance Affordability and Equity Act of 1999'.

SEC. 2. CREDIT FOR HEALTH INSURANCE COSTS OF PREVIOUSLY UNINSURED INDIVIDUALS AND INDIVIDUALS WITH COBRA COVERAGE.

(a) IN GENERAL- Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25A the following new section:

`SEC. 25B. HEALTH INSURANCE COSTS OF PREVIOUSLY UNINSURED INDIVIDUALS AND INDIVIDUALS WITH COBRA COVERAGE.

`(a) IN GENERAL- In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 60 percent of the amount paid during the taxable year for coverage for the taxpayer, his spouse, and dependents under qualified health insurance.

`(b) DOLLAR LIMITATION-

`(1) IN GENERAL- The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the sum of the monthly limitations for eligible months during such taxable year.

`(2) MONTHLY LIMITATION- The monthly limitation for any eligible month is the amount equal to 1/12 of--

`(A) $1,200 if, as of the first day of such month, the taxpayer has self-only coverage

under qualified health insurance, and

`(B) $2,400 if, as of the first day of such month, the taxpayer has family coverage under qualified health insurance.

`(3) ELIGIBLE MONTH- For purposes of this subsection--

`(A) IN GENERAL- The term `eligible month' means any month which begins at least 1 year after the most recent month that the individual--

`(i) was eligible to participate in any group health plan of an employer which provided qualified health insurance (determined without regard to subsection (d)(2)), or

`(ii) participated in any group health plan of any other entity which provided such insurance.

`(B) JOINT RETURNS- In the case of a joint return, a month shall be treated as an eligible month only if it is an eligible month of each spouse, determined by applying this paragraph separately to each spouse.

`(4) CERTAIN OTHER COVERAGE- Amounts paid for coverage of an individual for any month shall not be taken into account under subsection (a) if, as of the first day of such month, such individual is covered under any medical care program described in--

`(A) title XVIII, XIX, or XXI of the Social Security Act,

`(B) chapter 55 of title 10, United States Code,

`(C) chapter 17 of title 38, United States Code,

`(D) chapter 89 of title 5, United States Code, or

`(E) the Indian Health Care Improvement Act.

`(5) SPECIAL RULE FOR MARRIED INDIVIDUALS- In the case of an individual--

`(A) who is married (within the meaning of section 7703) as of the close of the taxable year but does not file a joint return for such year, and

`(B) who does not live apart from such individual's spouse at all times during the taxable year,

the limitation under paragraph (2)(A) (and not the limitation under paragraph (2)(B)) shall apply to such individual.

`(c) LIMITATION BASED ON ADJUSTED GROSS INCOME-

`(1) IN GENERAL- The aggregate amount which would (but for this subsection) be allowed as a credit under this section shall be reduced (but not below zero) by the amount determined under paragraph (2).

`(2) AMOUNT OF REDUCTION-

`(A) IN GENERAL- The amount determined under this paragraph shall be the amount which bears the same ratio to such aggregate amount as--

`(i) the excess of--

`(I) the taxpayer's modified adjusted gross income for such taxable year, over

`(II) the applicable dollar amount, bears to

`(ii) $10,000.

`(B) MODIFIED ADJUSTED GROSS INCOME- For purposes of this paragraph, the term `modified adjusted gross income' means adjusted gross income increased by any amount excluded from gross income under section 911, 931, or 933.

`(C) ROUNDING- Any amount determined under subparagraph (A) which is not a multiple of $10 shall be rounded to the next lowest $10.

`(3) APPLICABLE DOLLAR AMOUNT- For purposes of paragraph (2), the term `applicable dollar amount' means--

`(A) $60,000 in the case of a taxpayer whose qualified health insurance coverage covers more than 1 individual referred to in subsection (a), and

`(B) $30,000--

`(i) in any case not described in subparagraph (A), and

`(ii) in the case of a married individual filing a separate return.

For purposes of this paragraph, marital status shall be determined under section 7703.

`(d) QUALIFIED HEALTH INSURANCE- For purposes of this section--

`(1) IN GENERAL- Except as otherwise provided in this paragraph, the term `qualified health insurance' means insurance which constitutes medical care, as defined in section 213(d) without regard to--

`(A) paragraph (1)(C) thereof, and

`(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

`(2) EXCLUSION OF COVERAGE PROVIDED UNDER GROUP HEALTH PLANS, ETC- Such term shall not include insurance provided through any group health plan of an employer or any other entity.

`(3) EXCLUSION OF CERTAIN OTHER CONTRACTS- Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).

`(e) INDIVIDUALS WITH COBRA COVERAGE- In the case of continuation coverage under a group health plan which is required to be provided by Federal law for an individual during the period specified in section 4980B(f)(2)(B), notwithstanding subsection (d)--

`(1) such coverage shall be treated as qualified health insurance, and

`(2) the term `eligible month' includes months of such coverage.

`(f) SPECIAL RULES-

`(1) COORDINATION WITH OTHER DEDUCTIONS- No credit shall be allowed under this section for the taxable year if any amount paid for qualified health insurance is taken into account in determining the deduction allowed for such year under section 213 or 222.

`(2) DENIAL OF CREDIT TO DEPENDENTS- No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

`(3) INFLATION ADJUSTMENT-

`(A) IN GENERAL- In the case of a taxable year beginning after 2000, each dollar amount in subsection (c)(3) shall be increased by an amount equal to--

`(i) such dollar amount, multiplied by

`(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting `calendar year 1999' for `calendar year 1992' in subparagraph (B) thereof.

`(B) ROUNDING- If any amount as adjusted under subparagraph (A) is not a multiple of $100, such amount shall be rounded to the next lowest multiple of $100.'

(b) CLERICAL AMENDMENT- The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25A the following new item:

`Sec. 25B. Health insurance costs of previously uninsured individuals and individuals with COBRA coverage.'

(c) EFFECTIVE DATE- The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 3. DEDUCTION FOR QUALIFIED HEALTH INSURANCE COSTS OF EMPLOYEES AND SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL- Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 222 as section 223 and by inserting after section 221 the following new section:

`SEC. 222. COSTS OF QUALIFIED HEALTH INSURANCE.

`(a) IN GENERAL- In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount paid during the taxable year for coverage for the taxpayer, his spouse, and dependents under qualified health insurance.

`(b) APPLICABLE PERCENTAGE- For purposes of subsection (a)--

`(1) IN GENERAL- Except as provided in paragraph (2), the applicable percentage shall be determined in accordance with the following table:

`For taxable years beginning

--The applicable

in calendar year--

--percentage is--

2000

--60

2001

--70

2002

--80

2003

--90

2004 and thereafter

--100.

`(2) SPECIAL RULE- In the case of an individual who is an employee within the meaning of section 401(c)(1) and whose qualified health insurance is not provided through a group health plan of an employer, paragraph (1) shall be applied by substituting `100' for `90' but only with respect to the lesser of the taxpayer's earned income (within the meaning of section 401(c)) or the payments referred to in subsection (a).

`(c) EXCLUSION OF SUBSIDIZED COVERAGE- Subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any group health plan of an employer or any other entity if less than 50 percent of the cost of the taxpayer's coverage under such plan is borne by the taxpayer. A rule similar to the rule of the last sentence of section 162(l)(2)(B) shall apply for purposes of this subsection.

`(d) QUALIFIED HEALTH INSURANCE- For purposes of this section--

`(1) IN GENERAL- The term `qualified health insurance' has the meaning given such term by section 25B(d) determined without regard to paragraph (2) thereof.

`(2) SPECIAL RULE-

`(A) IN GENERAL- In the case of an individual who is an employee within the meaning of section 401(c)(1) and whose qualified health insurance (without regard to this paragraph) is not provided through a group health plan of an employer, paragraph (3) of section 25B(d) shall not apply for purposes of this section.

`(B) LIMITATION- The amount taken into account under subsection (a) by reason of subparagraph (A) shall not exceed the excess of--

`(i) the taxpayer's earned income (within the meaning of section 401(c)), over

`(ii) the amount which would (without regard to this paragraph) be taken into account under subsection (a).

`(e) SPECIAL RULES-

`(1) COORDINATION WITH MEDICAL DEDUCTION, ETC- Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

`(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES- The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.'

(b) CONFORMING AMENDMENTS-

(1)(A) Paragraph (1) of section 162(l) of such Code is amended by striking `the amount paid' and all that follows and inserting `the eligible long-term care premiums (as defined in section 213(d)(10)) paid during the taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering the taxpayer, his spouse, and dependents.'

(B) Paragraph (2) of section 162(l) of such Code is amended by striking subparagraph (C).

(2) Subsection (a) of section 62 of such Code is amended by inserting after paragraph (17) the following new item:

`(18) COSTS OF QUALIFIED HEALTH INSURANCE- The deduction allowed by section 222.'

(3) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

`Sec. 222. Costs of qualified health insurance.

`Sec. 223. Cross reference.'

(c) EFFECTIVE DATE- The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

END

For Immediate Release
July 1, 1999

Sean Rushton
(202)225-2571

Archer Plan to Provide Broad-Based Tax Relief

Will Also Focus on Health, Pensions, Education, Savings, Marriage Penalty, Capital Gains, and More

Effective Date of Capital Gains Relief will Be July 1st, 1999

WASHINGTON – Chairman Bill Archer (R-TX) today outlined the key components of his 1999 tax relief plan, due to be considered by the Committee the week of July 12th. Chairman Archer also stressed that Social Security and Medicare – which fall under the jurisdiction of the Committee on Ways and Means – are top priorities for the Committee in this session of Congress. In related news, the Congressional Budget Office today confirmed that the federal budget surplus generated solely by income taxes (the so-called "on-budget" surplus not related to Social Security and Medicare) will be roughly $996 billion over the next 10 years.

The Chairman's statement is as follows:

"Today, the real thanks and credit belong to the American taxpayer, whose hard work balanced the budget and whose hard-earned tax dollars produced this historic surplus which we celebrate today. And they deserve to keep more of the fruits of their labor.

Clearly, we agree with the President that our highest priorities should be shoring up Social Security and Medicare while maintaining our fiscal discipline, and we propose to use the magnitude of the budget surplus to accomplish these key goals for the American people. We're glad the President agrees with us that Social Security taxes should only go for Social Security. Period.

But once we've honored these commitments, so too must we honor our commitment to American taxpayers who created this budget surplus in the first place.

Americans are paying higher taxes today than at any time since World War II, and they have the right to pay less. The only reason for this surplus is because taxpayers are paying too much, which is why they deserve a refund. And if we don't cut taxes now and the money stays in Washington the politicians surely will spend it. We're going to put the bureaucrats in Washington on a diet so that the special interests can't go on a big government spending spree.

That's why we will use a major portion of the available surplus to reduce taxes on all Americans, whose income taxes have produced this surplus. While giving only targeted relief may have a political appeal to some, it would be wrong to deny relief to everyone who made this surplus possible. So this broad-based tax relief will be the largest item in my tax relief plan.

Marriage Penalty Relief: The marriage penalty increases the taxes on 42 million Americans for the simple reason that they are married. That's not fair – and my tax relief plan is going to bring relief to these married couples.

Education: The federal government has a limited role in the education of our schoolchildren, but within that role we should lighten the tax burden wherever possible to make education more affordable. So my plan will stop taxing school districts on the money they use to build new schools.

My plan will have other relief to make education more affordable and to give parents more choice as they do what's best for their children.

Health Care: To the greatest degree possible, we should level the tax incentives for acquiring health insurance so that more Americans can afford to buy coverage, and my plan will include significant relief to make health care more affordable and expand coverage.

Retirement Security, Death Tax, Pensions: Personal savings in the United States is at an all time low. My plan will protect savings that have already been taxed so that nest eggs and other retirement plans will be there for older Americans. My plan will also greatly reduce the death tax, create incentives to expand pensions for workers and their spouses, and will reduce the tax on capital gains.

Also, today I announce that the effective date for any capital gains relief in my tax plan is July 1st, 1999."

(This means that capital gains recognized today would be eligible for any lower rates that will be provided in Chairman Archer's 1999 tax relief bill. NOTE: This effective date, like the rest of the capital gains provisions, is contingent on its successful enactment into law, which includes Senate consideration and the President's signature).

"Finally, we will extend the expiring provisions, which include those on research and development, and those that help millions of Americans find jobs.

Yes, tax relief is a pillar of our plan to strengthen America in the 21st century, but it only one part of our overall plan. We're going to work hard to save Social Security, strengthen Medicare, and help with the high cost of prescription drugs. And we're going to pay down the debt. But we owe the biggest debt to the American taxpayer, and it's time to start repaying it."

-30-

For Immediate Release
June 30, 1999

Sean Rushton
(202)225-2571

Archer Statement on President's Medicare Proposal:

WASHINGTON – Chairman Bill Archer (R-TX) today issued the following statement in response to President Clinton's Medicare proposal to include prescription drugs.

"Giving seniors affordable access through Medicare to the latest advances in drug therapies is a high priority for House Republicans. The President's proposal is a positive contribution as Congress deliberates the best way to provide prescription drugs to America's seniors while modernizing and preserving Medicare for the 21st Century.

"No senior should ever face the burdensome decision of choosing between their drugs and other basic necessities such as food. That's why Republicans strengthened Medicare two years ago with programs such as Medicare+Choice, where 95 percent of beneficiaries currently have prescription drug coverage. Moreover, our efforts to meet the health care needs of Medicare's 39 million seniors and disabled while controlling wasteful spending have successfully extended the life of Medicare until 2015.

"Republicans want to make sure that we provide a market-oriented drug benefit in a way that does not threaten to bankrupt Medicare and deny existing coverage to millions of seniors and the disabled. Additionally, we must seek a fiscally sound solution that will build upon the 25 million Medicare beneficiaries who already have prescription drug coverage.

"As Congress debates the addition of a costly new prescription drug benefit, it should heed the lessons learned in 1988 with the passage and later repeal of the Medicare Catastrophic Coverage Act. Coverage of prescription drugs was a major cornerstone, yet once seniors realized the increased costs of the new benefit would be paid by them in the form of higher premiums and surcharges, they overwhelmingly rejected the plan.

"I look forward to working with the Administration and our Democratic colleagues in the House in a bipartisan manner to craft an affordable prescription drug benefit while maintaining our commitment to ensure the long-term solvency of Medicare."

-30-

As published in *The Dallas Morning News* on Sunday, January 31, 1999

Saving Social Security and Reducing the Tax Burden: We Can Do Both

By Congressmen Bill Archer

The Social Security program is headed for bankruptcy. Without change, this program, on which so many Americans rely, will reach financial crisis in 2013 when payroll taxes collected will be insufficient to cover its costs.

Without reform, Social Security will only be able to survive in the future through massive tax increases on workers and draconian benefit cuts that will hurt the aged. If we enact reforms today, rather than waiting for the inevitable crisis, this dilemma can be avoided. Luckily, we are in a strong position to make the changes necessary.

Thanks to sound fiscal policy, reduced government spending and good old-fashioned American productivity, the federal government is projected to run budget surpluses of $4.4 trillion — yes, trillion! — over the next 15 years. The economy has been growing — except for a brief downturn in the early '90s — for 17 years, since Ronald Reagan's tax cuts went into effect in 1982.

Thanks to this tremendous bounty, we can now afford to begin the transition to the Social Security System of the 21st Century: one that will be fair to current and future retirees, especially women; one that will not need to raise taxes to survive; one that will maintain a basic safety net for all Americans; and one that will provide younger workers with new choices and opportunities to build wealth through the power of compound interest.

The President has called for 62 percent of the total budget surplus — that's $2.7 trillion — to be reserved until Social Security is saved. Republicans should work with the President and "wall off" this huge sum from spending or tax cuts until Social Security is no longer at risk. That leaves us with a total of $1.7 trillion in leftover surplus money which will be taken out of your paycheck every month and sent to Washington, DC. When workers file their taxes, they don't tell Uncle Sam to "keep the change." Working people are paying too much and getting too little back — it is time for sizable, growth-oriented tax cuts. The case for tax reduction is clear. Americans pay more in taxes — close to 40 percent for the average family — than at any other time in peacetime history. Most citizens today pay more for their government than they do for food, medicine and shelter combined. Many families, who would prefer to have one parent at home with the kids, are forced to send both out to work — one to earn a salary, one to pay the taxes. Meanwhile, the President — the same one who told us "The era of big government is over," recently submitted a budget that would raise taxes and fees on working people by $108 billion, create 40 new mandatory government programs, and 80 new discretionary programs.

According to an analysis by the National Taxpayers Union Foundation, the President's proposals would increase net federal spending by $288 billion per year. Is big government really a thing of the past? Already we have seen 25 percent of the 1999 surplus allocated to supplemental spending, including aid for the people of Bosnia. If a huge pile of extra money is kept in Washington, not only will it be frittered away but it may very well also lead to all kinds of mischief, as federal agencies and other bureaucrats clamor for new funding to invade larger swaths of American life. Our federal government works best when it is limited to a few specific roles which it can perform well, and otherwise permits people to make their own decisions. Not only will tax cuts re-impose a sense of fiscal discipline on the "kid-in-a-candy-store" spending atmosphere in Washington, DC, they will also promote economic growth by returning capital to the productive private sector. With much of the

world spiraling in economic malaise, boosting our economic strength through tax cuts may be just the thing to keep America free of recession.

Working together, Congress and the President should make saving Social Security a top priority for this generation and the next. But it is also time to return to the working Americans who earned it in the first place a significant a portion of the remaining $1.7 trillion surplus. We can save and strengthen Social Security, cut taxes and pay down the national debt. That is our Republican goal for the people of our country.

For Immediate Release
January 12, 1999

Sean Rushton
(202)225-2571

Archer Tax Relief Bill Will Include Three-Point Plan for Long-Term Health Care Needs

-- 100% Deduction for Long-Term Care Premiums, Additional Exemption for Family Members Caring for Elderly at Home, Other Changes –

WASHINGTON – Ways and Means Chairman Bill Archer (R-TX) today announced that his 1999 tax relief plan will include a three-point plan to help older Americans and their families with the growing needs of long-term health care. An outline of Archer's plan follows this release.

"The need for long-term care in America is great and will only grow larger as the baby boomers start retiring in the next decade. My plan will help make long-term care more affordable for millions of Americans and will also help those caring for their parents or loved ones at home," said Chairman Archer.

Archer's long-term care plan includes: 100% Deduction for Long-Term Care Premiums: The plan will provide individuals who purchase long-term care insurance with a phased-in 100% tax deduction on their insurance premiums.

Additional Exemption for Taxpayers Caring for Elderly Family Members at Home: The plan will provide taxpayers caring for elderly family members at home with an additional personal exemption (currently $2,750) when filing income tax returns.

Employee Benefit Plans Will Now Be Permitted to Include Long-Term Care Insurance: The plan will permit employers for the first time to include long-term care insurance as part of "cafeteria" benefits plan, where employees could dedicate pre-tax wages toward the purchase of long-term care insurance

Other health care provisions in Chairman Archer's plan may be released at a later date. Chairman Archer is expected to announce all of the components of his 1999 tax relief plan as early as next week, and the Ways and Means Committee will consider the bill shortly thereafter. The House and Senate budget resolution requires the Ways and Means Committee to report a bill no later than July 16th.

EXPANDING HEALTH CARE COVERAGE

1999 Taxpayer Relief Plan

Three-Point Plan for Long-Term Care

100% Deduction for Long-Term Care Premiums:

The plan will provide individuals who purchase long-term care insurance with a 100% tax deduction on their insurance premiums. The provision will be phased in over 10 years.

• 7.3 million Americans now need long-term care services, whether at home or in a nursing home facility.

• 19 million Americans are expected to require long-term care by 2050.
• According to the Health Insurance Association of America (HIAA), in 1996 the average annual base premium for leading long-term care insurers was $364 for persons at age 50, $980 for persons at age 65, and $3,907 for persons at age 79.

Additional Exemption for Taxpayers Caring for Elderly Family Members at Home:

The plan will provide taxpayers caring for elderly family members at home with an additional personal exemption (currently $2,750) when filing income tax returns. • The National Alliance for Caregiving estimates that nearly 25% of American households care for an elderly relative or friend at home, with the typical caregiver identified as a 46-year-old working woman.
• A national study by AARP found that 50% of working caregivers reported financial strain and 40% missed work on a regular basis due to health needs of an elderly loved one.

Employee Benefit Plans Will Now Be Permitted to Include Long-Term Care Insurance:

The plan will permit employers for the first time to include long-term care insurance as part of a "cafeteria" benefits plan offered to workers. If the plan were enacted, employees would be able to dedicate pre-tax wages toward the purchase of long-term care insurance.

-30-

Your Money & Your Health

Small Business and the Self-Employed Can Now have Medical Savings Accounts

By Congressman Bill Archer
Fall 1997

The 104th Congress delivered on its promise to pass common sense health care reform. H.R. 3103, the *Health Coverage Affordability, Accountability and Availability Act of 1996*, was passed into law in the summer of '96. I was a principal author of the bill that uses private sector initiatives to improve health care coverage for all Americans.

In 1993, we witnessed President Clinton's far reaching attempt to pass a government takeover of our health care system. But the American people soundly rejected it and until the new majority in Congress took over, no improvements in our health care system had been achieved.

H.R. 3103 guarantees portable health insurance for all Americans. No longer do individuals with preexisting conditions need to fear that if they lose their jobs they will lose their health insurance forever. Nor do Americans need to stay locked in a job for their entire careers because they would not be eligible for health insurance under a new employer.

But portable health insurance is of little use unless it is affordable. Medical savings accounts (MSAs) are an essential part of reform if we want to make health insurance affordable.

How MSAs Work

Medical savings accounts are simple. If you are self-employed or work for a small business with less than fifty employees, you are eligible. You or your employer could put up to 65% of your deductible for an individual policy or 75% of your deductible for a family policy into an MSA.

This money put into the MSA would not be included in your taxable income, and any dollar you spent from the MSA on medical services would not be taxed either. If you used the money for something other than medical services, it would be taxed and would be subject to a fifteen percent penalty.

Employers who used these accounts would accompany them with a low-cost, high deductible insurance policy that only covers medical costs over the deductible.

At the end of the year, the money not used in your MSA can be withdrawn tax-free for future medical expenses. At retirement, the money would be yours to keep.

Medicare MSAs

The Balanced Budget Act of 1997 offered several new choices for Medicare recipients including MSAs. A Medicare MSA works similarly to a regular MSA except that the Department of Health and Human Services, and not you directly, makes tax free annual contributions to your Medicare MSA.

Simplicity

With an MSA, once you've visited the doctor, you would write your check from your account and go on your way. There would be no one looking over your shoulder to second guess you. The doctor wouldn't have to file any claims. And you would have another incentive to stay well if you knew that it would mean more money for you to keep.

Saving for the Future

But medical savings accounts won't just help your physical health. They could help your fiscal health by providing you with much needed savings for your future.

By putting them off-limits to taxation, these accounts would become like medical IRAs. The amount not used each year would accrue more and more over time and provide a retirement nest egg.

Making Health Care Affordable

MSAs also provide health insurance stability to the individual between jobs. An unemployed job seeker with an MSA could more likely maintain an inexpensive, high deductible plan. Without an affordable health care option, the temporarily uninsured individual unnecessarily runs the risk of financial catastrophe.

MSAs put you in the driver's seat when spending your health-care dollars. The less you spend, the more you keep. Individuals will become better consumers of health care and help keep costs down. Contact your local insurance company if you want to sign up for an MSA.

The Taxpayer Relief Act of 1997 contains another measure to make health care affordable. The Taxpayer Relief Act increases the deductibility of health care costs for the self employed that Clinton allowed to expire in 1993. The current health insurance deductibility would increase incrementally from 30% to 100% by 2007.

Putting Patients First

The medical savings accounts initiative returns control of the health care system back to the patient.

The Health Care Availability, Accountability and Affordability Act of 1996 and medical savings accounts give Americans both portable and affordable health insurance. We have taken an important step to provide better health insurance options to millions of Americans while staying within the American principles of freedom.