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NEWS FROM THE HOUSE DEMOCRATIC LEADER

For Immediate Release:
September 28, 1999

House Democratic Leader Richard A. Gephardt
H-204, U.S. Capitol

Gephardt Statement on Republican Health Care Access "Proposal"

"Nine months into this session of Congress, Republicans have suddenly found religion on the issue of expanding health care coverage for uninsured Americans. This is a cynical, desperate, last-minute attempt to stave off a bipartisan managed care bill on the verge of passage, not a genuine effort to pass legislation to benefit uninsured Americans. Once again, Republicans show why they are unable to govern -- they pursue policy through press releases, not through a serious, sustained effort to pass sensible legislation through the normal process.

"House Republicans have been absent on the issue of expanding health care coverage for years. Democrats welcome their sudden awareness of its critical importance, no matter how belated or insincere. As anyone who has followed this issue knows, President Clinton and Congressional Democrats have been working over the past decade get every American covered by insurance, always in the face of Republican intransigence or outright opposition to our efforts. To suggest that Democrats have ignored these issues in favor of HMO reform is dishonest and incorrect.

"Some of these proposals are worthy of our support; Democrats have supported a number of them in the past. But the price tag of this cumulative package would run into the billions. I am curious about where Republicans will find the money to pay for these proposals, considering they are already dipping into the Social Security surplus to the tune of \$16 billion to pay for their other government spending. Is this a cruel, empty promise, or is it serious? Democrats will only support a bill that is fully paid for -- without budget gimmickry -- and doesn't raid Social Security.

"This is not an 'either-or' choice: we can pass HMO reform and act to expand health care coverage for uninsured Americans. In fact, managed care reform benefits both the people who are already covered by insurance today, as well as those who will most likely be using managed care when they get coverage in the future. If Republicans truly want to increase access for the millions of uninsured Americans, let's take up the debate as the first order of business after we pass HMO reform."

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Contact: Laura Nichols/Sue Harvey (202) 225-0100

NEWS

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
September 28, 1999

CONTACT: Trent Duffy or Greg Crist
(202) 225-8933

Helping Americans With Cost of Health Insurance is Top Priority 43 Million Uninsured Americans Not Helped by HMO Reform

***– Archer Announces New Tax Incentives to Make
Health Insurance More Affordable & Accessible –***

WASHINGTON – Rep. Bill Archer (R-TX), Chairman of the Committee on Ways and Means, announced today several health care tax incentives to increase access and affordability for the 43 million Americans without health insurance. The Quality Care for the Uninsured Act will include the health care provisions found in the Taxpayer Refund and Relief Act, including 100% deductions of health insurance, long-term care deductions, and 100% premium deductions for the self-employed.

“Our top health care priority is helping more Americans obtain health insurance, and our plan does that. Frankly, all the lawsuits in the world won’t do a thing for a worker struggling to buy health insurance for themselves or their family,” said Chairman Archer.

Highlights of health care tax incentives include:

100% Deduction for Health Insurance Premiums: The plan will provide individuals who purchase health insurance a 100 percent deduction on their insurance premiums. Moreover, the deduction will be “above-the-line,” meaning individuals will be allowed to take the deduction whether or not they itemize deductions on their tax forms.

100 Percent Deduction of Health and Long-Term Care Insurance Costs for Self-Employed: The plan will provide self-employed individuals who purchase health and long-term care insurance to deduct 100 percent of their premiums beginning Jan. 1, 2001 – a 2-year acceleration. Deductions will also be “above-the-line.” The plan would help over 5 million self-employed individuals currently without health insurance. Under current law, the self-employed may only deduct 60 percent of their premiums; an amount that gradually increases to 100 percent by 2003.

100% Deduction for Long-Term Care Premiums: The plan will provide individuals who purchase long-term care insurance with a 100% above-the-line tax deduction on their insurance premiums. 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 health care by 2050.

-more-

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.

Cafeteria 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.

Expands Medical Savings Accounts (MSAs) for more Americans: The plan, for the first time, permits all individuals (not just those employed by small employers and the self-employed) to have Medical Savings Accounts (MSAs), and allows both employers and employees to contribute jointly to MSAs. The plan also expands eligibility rules related to the minimum deductible amount so that more people can qualify, repeals the 750,000 cap on taxpayer participation and makes MSAs permanent.

Cafeteria Benefit Plans Will Now Be Permitted to Include MSAs: The plan will permit employers for the first time to include MSAs 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 MSAs.

Orphan Drug Tax Credit to Find Cures for Rare Diseases: The plan expands tax credits for experimental drug testing for rare diseases (affecting less than 200,000). Taxpayers presently get a 50% credit for research and development expenses related to human clinical tests for the treatment of rare diseases **if approved** by the FDA. The Orphan Drug credit would be extended to include those clinical testings before FDA approval. The credit encourages companies to begin clinical trials without waiting for FDA approval of the tests. If the drug is successful, then the company could seek the credit retroactively.

Medical Innovation Tax Credit: The plan permits a taxpayer to claim a 40 percent credit for qualified medical research costs for human clinical testing of any drug, biologic, or other medical device. Qualified research applies only to certain academic institutions.

Adds Certain Vaccines Against Streptococcus Pneumoniae to the List of Vaccines and Reduces Vaccine Excise Tax: In addition to adding streptococcus pneumoniae to the list of taxable vaccines, the plan also reduces the excise tax from 75 cents per dose to 50 cents per dose for sales after December 31, 2004.

J. Dennis Hastert
Fourteenth District
Illinois

<http://speaker.gov>

Speaker's Press Office

United States House of Representatives
Washington, DC 20515

FOR IMMEDIATE RELEASE:
TUESDAY, September 28, 1999

CONTACT: 202-225-2800
Pete Jeffries or John Feehery

Statement of House Speaker Dennis Hastert (R-IL) Regarding Increasing Health Care Coverage for the Nation's 44-Million Uninsured Americans

WASHINGTON—Speaker of the House Dennis Hastert (R-IL) today made the following statement at a news conference in the U.S. Capitol:

"As one who has been involved in our nation's health care policy for a long time, I'm pleased to join my colleagues here today to help increase access to affordable health care coverage. We're here because one-out-of-every-six Americans currently doesn't have the peace of mind that health care protection provides, and it would be irresponsible to go forward with health care reform without addressing this critical need.

"We must give Americans more control over health care choices because the most basic patient protection is health care coverage in the first place. Republicans are committed to providing patients the care they need, when they need it, by ensuring quality health care with more options.

"While the Democrats say they're for health care reform, I must point out that none of their managed care proposals they support comes close to providing coverage for the uninsured. For instance, what does the Dingell-Norwood bill do for the uninsured? NOTHING. In fact, it has the dubious distinction of actually adding millions more people to the ranks of the uninsured because they increase health care costs.

"And what is one of the leading Democrat presidential candidates, Bill Bradley, proposing today? I would certainly hope that it's not the already failed ClintonCare plan of government-run health care, which the American people overwhelmingly rejected in 1994.

"For those reasons and many more, I'm proud to announce that the *Quality Care for the Uninsured Act* unveiled today by Chairman Jim Talent and Congressman John Shadegg will be considered in the House next week to help us address this most pressing problem – increasing access to quality health care.

(MORE, MORE, MORE)

PAGE TWO

Speaker's Statement on Health Care for the Uninsured
September 28, 1999

"While accountability in health care is an important aspect of the managed care debate, there are 44-million other reasons why House Republicans are broadening the focus to also include accessibility & affordability of health care – those being the 44-million Americans without health care coverage today.

"When the Clinton-Gore Administration took over in 1993, there were 38-million uninsured Americans. It's swelled to 44-million uninsured Americans today, and even worse is that number will continue to rise by 1-million Americans each year in the 21st Century if nothing is done now to enhance accessibility & affordability in our health care system.

"I have always said that if health care coverage isn't affordable – it isn't accessible. Costs and coverage go hand-in-hand. Because of that, there are 44-million uninsured Americans from coast-to-coast, mostly because current costs and too few options prevent themselves or their employers from purchasing health care coverage.

"The *Quality Care for the Uninsured Act* will help change that. This responsible, common-sense legislation helps create new avenues to quality health care so more people can be covered. The bill includes tax-free Medical Savings Accounts, 100 percent tax deductibility of individual insurance premiums for the self-employed and uninsured, as well as the development of Association Health Plans, Community Health Center Networks, and HealthMarts. These bold, new initiatives will put the health care market to work for individuals by creating new choices and making health care coverage more affordable, more accessible, and more accountable.

"I look forward to next week's health care debate, particularly so we can focus more attention to increasing health care coverage for America's 44-million uninsured through new options and market-based reforms. And in closing, I challenge the Democrats to put forward responsible legislation that creates new avenues to affordable and accessible health care to cover our nation's uninsured – not new tax hikes or costly mandates, but legitimate legislation to increase quality care for America's uninsured."

-- *Dennis Hastert (R-IL)*
Speaker of the House

**HIGHLIGHTS OF DOL'S PATIENTS' RIGHTS PROPOSED REGULATION
ENSURING FASTER, FAIRER, & FULLER HEALTH CARE CLAIMS
PROCEDURES**

I. FASTER DECISIONS

1. Faster initial coverage decisions. Old rule: 90 days. New rule: 72 hours (urgent care), 15 days.
2. Faster appeals. Old rule: 60 days. New rule: 72 hours (urgent care), 30 days.
3. In urgent care situations, decisions may be communicated orally.

II. FAIRER PROCESS

1. Plans may not preclude individuals from representing patients, and in urgent care situations, the patient's doctor will be deemed to be a representative.
2. Plans cannot impose fees or costs as a condition to making or appealing a claim.
3. More time for patients to file appeals. Plans must give patients at least 180 days to decide whether to appeal the denial.
4. The decisionmaker on appeal must be different from, and not subordinate to, the decisionmaker at the initial stage. And, the decisionmaker on appeal must consult with a qualified health care professional who is different from, and not subordinate to, any health care professional who part in the initial denial.
5. If plan doesn't comply with regulation patient can take claim immediately to court.
6. Arbitration with safeguards is permitted.

III. FULLER DISCLOSURE

1. When a worker enrolls in a health plan, the worker must get a full description of the plan's claims procedures.
2. When a plan denies a claim, the patient must get a very specific written explanation of the reasons for the denial, and of his or her appeal rights.
3. When a plan denies a claim, the patient can get access to all documents, records, and information relevant to the claim.
4. When conducting an appeal, the plan may not rubberstamp the initial denial; the reviewer must make a new finding, considering any new evidence submitted.

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U.S. House of Representatives Committee on Commerce

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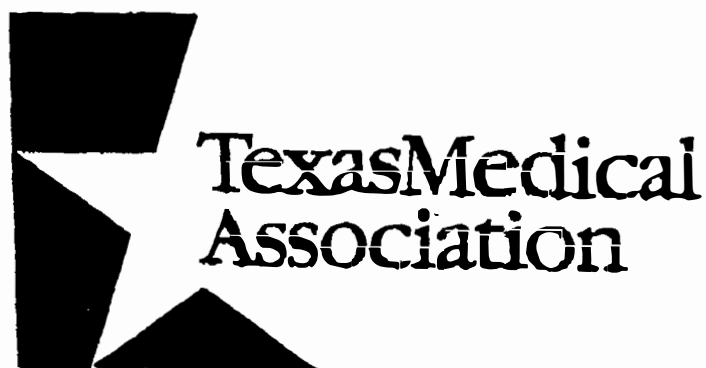
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Texas Liability

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MANAGED CARE LIABILITY TEXAS LEGISLATION SUMMARY AND BILL



AUGUST 1997

SB 386--MANAGED CARE RESPONSIBILITY ACT BY SIBLEY/SMITHEE

RESPONSIBILITY

This measure provides that health insurance carriers, health maintenance organizations and other managed care entities have the responsibility to exercise ordinary care when they make a health care treatment decision involving necessary medical treatment for their insureds. They may also be responsible for the acts of their employees, agents and representatives acting on their behalf. This act only involves medical services covered by the health care plan and does not require them to provide services which are not covered by the plan. Employers are specifically excluded from liability under the act. Managed care organizations (MCO) are prohibited from retaliating against a health care provider for advocating on behalf of the patient. Managed care organizations also may not have indemnification and hold harmless clauses in their contracts with providers.

LIMITATIONS OF CAUSE OF ACTION

Ordinarily a patient cannot bring a liability action under this legislation without exhausting the internal appeals process and the independent review process provided in this legislation. If the patient has failed to do this, the patient is required to give a 30 day notice to the managed care organization who has 14 days to request that the patient submit to an independent review. If the harm has already occurred because of the conduct of the MCO and such review would not be beneficial to the patient, suit can be filed without going through the independent review unless the patient was found to be acting in bad faith to avoid the review process. If the patient failed to comply with the appeals and review process, the court has the authority to order the patient to submit to an independent review or to mediation, or other alternate dispute resolution and abate the action for up to 30 days.

INDEPENDENT REVIEW OF MANAGED CARE DECISIONS

This legislation provides that a patient has the right to the review of a denial of medical services by the managed care organization by an independent review organization (IRO). This independent review organization is certified by the commissioner of insurance and it is the commissioner who makes the assignment for the review. The commissioner sets the standards for certification. The review must occur within the earlier of 15 days after the date the IRO receives the necessary documents for review or 20 days after the request for review is received. In the case of a patient with a life-threatening condition, the patient has the right to skip the internal appeals process of the MCO and appeal directly to an independent review organization. The review by the IRO must be completed within the earlier of 5 days after receiving the necessary documents or 8 days after receipt of the request for review.

SB386--MANAGED CARE RESPONSIBILITY ACT BY SIBLEY/SMITHEE

SECTION 1. CHAPTER 88. HEALTH CARE LIABILITY

Sec. 88.001. DEFINITIONS

(1) "Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means a person enrolled in a health care plan and includes covered dependents.

(3) "Health care plan" means any plan which provides, arranges for, pays for or reimburses any part of the cost of any health care services.

(4) "Health care provider" uses the definition from Art. 4590i.

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and insurance in Texas.

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act.

(8) "Managed care entity" means any entity which delivers, administers, or assumes risk for health services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations or the employer of a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means (1) an individual licensed to practice medicine; (2) a professional association or 5.01(a) non-profit entity; or (3) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization or managed care entity, that degree of care that such an entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use under the same or similar circumstance.

Sec. 88.002. APPLICATION

(a) A health insurance carrier, health maintenance organization or managed care entity (for purposes of this summary hereinafter referred to as "managed care organization" or "MCO") for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A managed care organization is also liable for damages for harm to a . insured or enrollee proximately caused by the health care treatment decisions made by its employees, agents, ostensible agents, or representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control

(c) It shall be a defense to any action against a managed care organization if the organization or its employees, agents or representatives for whose conduct the organization is liable did not participate in a health care treatment decision and did not deny or delay recommended treatment.

(d) This section creates no obligation on the managed care organization to provide treatment for services which are not covered by the plan.

(e) This chapter does not create any liability on the part of an employer or a pharmacy.

(f) A managed care organization may not remove a health care provider from its plan or fail to renew for advocating on behalf of the patient for necessary medical care.

(g) MCO's may not include indemnification or hold harmless clauses in their contracts with providers.

(h) A managed care organization may not assert the prohibition of the corporate practice of medicine as a defense.

(i) A physician or other health care provider may not be regarded as an employee, agent or representative of an MCO merely because the physician's or health care provider's name appears on an approved list of providers.

(j) This chapter is not applicable to Worker's Compensation cases.

(k) A plaintiff under this section shall comply with the expert witness and cost bond requirements of the Medical Liability and Improvement Act (Sec. 13.01, Art. 4590j)

Sec. 88.003. LIMITATIONS ON CAUSE OF ACTION

(a) A person may not maintain a cause of action under this chapter unless he has exhausted the appeals process of the MCO and the independent review or gives notice of the claim to the managed care organization and agrees to submit to an independent review as provided in subsection (c).

(b) The notice in (a) must be provided 30 days before the claim is filed.

(c) The enrollee must submit to an independent review if requested by the managed care organization. Such request by the MCO must be made within 14 days of its receipt of notice of the claim.

(d) If the party has failed to complete the appeals process and independent review process required in subsection (a), the court cannot dismiss the action but has the authority to order the enrollee to submit to an independent review or mediation or other nonbinding alternate dispute resolution and may abate the action for a period not to exceed 30 days.

(e) The enrollee is not required to comply with subsection (d) if (1) the harm has already occurred because of the conduct of the managed care organization and (2) the review would not be beneficial to the enrollee unless the court finds that such pleading was not filed in good faith.

(f) The statute of limitations is tolled when the enrollee is required to comply with the appeals process of the MCO and the independent review or to give notice of the claim.

(g) This chapter does not preclude the enrollee from pursuing other appropriate

relief available under law (including injunctive relief) when exhausting the appeal and review process would place the enrollee's health in serious jeopardy.

SECTION 2. UTILIZATION REVIEW APPEALS AND INDEPENDENT REVIEW

(1) Provides that notification of a determination of an appeal within the MCO appeals process must be given within 30 days of the notice of the appeal and that notice should be given of the enrollee's right to appeal to an independent review organization(IRC).

(2) When a "life-threatening condition" is involved, the enrollee is entitled to an immediate appeal to an IRO without exhausting the MCO's internal appeals process. "Life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

SECTION 3. INDEPENDENT REVIEW OF ADVERSE DETERMINATION

A utilization review agent shall:

- (1) permit any denial to be appealed to an independent review organization;
- (2) provide medical records, pertinent information and notice to IRC within 3 business days;
- (3) comply with decision of IRO; and
- (4) pay for the review.

SECTION 4. CONFIDENTIAL INFORMATION

Confidential information can be provided to the IRO by the utilization review agent subject to rules adopted by the commissioner.

SECTION 5. HMO NOTICE TO ENROLLEE OF RIGHT TO IRO

An HMO is required to give notice to the enrollee of the right to appeal an adverse determination to an IRO.

SECTION 6. COMPLAINT SYSTEM

The commissioner is given the right to examine the HMO's complaint system.

SECTION 7. REVIEW OF ADVERSE DETERMINATIONS

(a) The HMO complaint system must include the following:

- (1) notification to the enrollee of the right to appeal to an IRO;
- (2) notification to the enrollee of the procedure for such appeal;
- (3) notification to an enrollee who has a life-threatening condition of the right to an immediate review by an IRO and the procedure for doing so.

(b) Provisions in UR statute relating to IRO's also apply to HMO's.

(c) (1) "Adverse determination" means a denial of care as not being medically necessary.

(2) "Independent review organization" means an organization as defined in 21.58C of the Insurance Code.

(3) "Life-threatening condition" has the meaning assigned in the UR Act.

SECTION 8. Art. 21.58C. STANDARDS FOR UTILIZATION ORGANIZATIONS

Sec. 1. DEFINITIONS

- (1) "Life-threatening condition" has the meaning assigned in the UR Act (Art. 21.58A, Insurance Code)
- (2) "Payor" has the meaning assigned by the UR Act.

Sec. 2. CERTIFICATION AND DESIGNATION OR INDEPENDENT REVIEW ORGANIZATIONS.**(a) The commissioner shall:****(1) promulgate rules and standards for:**

- (A) the certification, selection and operation of IRO's; and
- (B) the suspension and revocation of a certification;

(2) designate annually each organization that meet the standards;**(3) charge payors fees necessary to fund the operations of the IRO's; and****(4) provide ongoing oversight of the IRO's to ensure compliance.****(b) The standards required shall ensure:****(1) the timely response of the IRO;****(2) the confidentiality of medical records;****(3) the qualifications and independence of each health care provider making review determinations for an IRO;****(4) the fairness of the procedure used by the IRO; and****(5) timely notice to the enrollee of the results including the clinical basis for the decision.****(c) The standards must require the IRO to make its determination:****(1) not later than the earlier of:****(A) the 15th day after the date the IRO receives the information necessary to make the determination; or****(B) the 20th day after the date the IRO receives the request for the determination;****(2) in the case of a life-threatening condition, not later than the earlier of:****(A) the 5th day after the date the IRO receives the information necessary to make the determination; or****(B) the 8th day after the date the IRO receives the request that the determination be made.****(d) The application of an organization seeking approval to be an IRO must include:****(1) name of each stockholder or owner of more than 5% of any stock or options;****(2) the name of any holder of bonds or notes of the applicant that exceed \$100,000;****(3) the name and type of businesses that is owned or affiliated with the applicant;****(4) the name and biographical sketch of each officer, director and executive of the applicant and a description of certain relationships;****(5) the % of applicant's revenues expected to be earned from reviews;****(6) a description of the areas of expertise of the professional to be making the determinations; and**

(7) the procedures to be used in making determinations.

(e) The IRO shall annually submit this information and shall update the information when a material change occurs.

(f) An IRO may not be owned by payors or a trade association of payors.

(g) An IRO has immunity from liability for conducting review, unless acting in bad faith or grossly negligent.

SECTION 9. Chapter 88, the liability section applies to actions accruing on or after the effective date of the Act.

SECTION 10. (a) The change in law in Sections 2 through 4 and 6 through 8 apply to adverse determinations made after the effective date of this Act.

(b) The change in Section 5 of this Act applies to evidence of coverage that is delivered, issued for delivery, or renewed on or after Jan. 1, 1998.

SECTION 11. This Act takes effect of Sept. 1, 1997.

SECTION 12. EMERGENCY CLAUSE

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**THE
CATHOLIC HEALTH
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OF THE UNITED STATES**

STATEMENT

of

REVEREND MICHAEL D. PLACE, STD

**President and Chief Executive Officer
The Catholic Health Association of the United States**

October 7, 1999



The Catholic Health Association of the United States (CHA) contacted Representatives Norwood and Dingell, sponsors of the Bipartisan Consensus Managed Care Act of 1999, to express serious concern about a technical amendment made yesterday in H.R. 2723 that would, in CHA's interpretation, effectively remove the appropriate conscience protection Catholic health plans would have enjoyed under Title I of the bill as originally introduced. CHA regarded this protection as critical in ensuring that Catholic-sponsored health plans would not be required to provide, or reimburse for, advice and counseling for services or procedures that are antithetical to their religious beliefs and moral convictions.

Upon learning of our concern, both Dr. Norwood and Mr. Dingell called me personally this morning to pledge that they would work cooperatively with CHA to resolve the problem.

I accept and trust their personal pledges. We will begin on Monday to assure that Catholic health plans are free to act in a manner consistent with their religious beliefs.

NATIONAL HEADQUARTERS

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St. Louis MO 63134-3797

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DEPUTY CHIEF OF STAFF

OCT 06 1999

Honorable Edward M. Kennedy
United States Senate
SR-315
Washington, DC 20510

Dear Senator Kennedy:

This is in response to your letter of October 4, 1999, requesting revenue estimates and other information concerning several of the health care tax provisions in the conference agreement on H.R. 2488 and two of the health care tax provisions in S. 1344.

The conference agreement on H.R. 2488 contains an above-the-line deduction for health insurance expenses and long-term care insurance expenses for which the taxpayer pays at least 50 percent of the premium. The deduction would be phased in at 25 percent for taxable years beginning in 2002 through 2004, 35 percent for taxable years beginning in 2005, 65 percent for taxable years beginning in 2006, and 100 percent for taxable years beginning in 2007 and thereafter. Taxpayers enrolled in Medicare, Medicaid, Champus, VA, the Indian Health Service, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program would be ineligible for the deduction for health insurance expenses.

The conference agreement on H.R. 2488 also contains a provision that would allow long-term care insurance to be offered as part of cafeteria plans, effective for taxable years beginning after December 31, 2001.

For the purpose of preparing revenue estimates for these provisions in H.R. 2488, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2002 about 9.1 million taxpayers would claim the 25-percent deduction for health insurance expenses. About 100,000 of these 9 million taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 200,000 persons would be newly insured as a result of the 25-percent deduction for health insurance expenses.

We estimate that in calendar year 2002 about 4.7 million taxpayers would claim the 25-percent deduction for long-term care insurance expenses, and an additional 300,000 taxpayers

Congress of the United States
JOINT COMMITTEE ON TAXATION
Washington, DC 20515-6453

Honorable Edward M. Kennedy
United States Senate

Page 2

would use cafeteria plans to pay their share of premiums for employer-sponsored long-term care insurance. About 80,000 of these 5 million taxpayers would be new purchasers of long-term care insurance.

S. 1344 contains a provision that would increase the deduction for health insurance expenses of self-employed individuals. Under present law, when certain requirements are satisfied, self-employed individuals are permitted to deduct 60 percent of their expenditures on health insurance and long-term care insurance. The deduction is scheduled to increase to 70 percent of such expenses for taxable years beginning in 2002 and 100 percent in all taxable years beginning thereafter. S. 1344 would increase the rate of deduction to 100 percent of health insurance and long-term care insurance expenses for taxable years beginning after December 31, 1999.

S. 1344 also contains provisions that would eliminate certain restrictions on the availability of medical savings accounts, remove the limitation on the number of taxpayers that are permitted to have medical savings accounts, reduce the minimum annual deductibles for high-deductible health plans to \$1,000 for plans providing single coverage and \$2,000 for plans providing family coverage, increase the medical savings account contribution limit to 100 percent of the annual deductible for the associated high-deductible health plan, limit the additional tax on distributions not used for qualified medical expenses, and allow network-based manage care plans to be high-deductible plans. These provisions would be effective for taxable years beginning after December 31, 1999.

For the purpose of preparing revenue estimates for these provisions in S. 1344, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2000, about 3.3 million taxpayers would claim the 100-percent deduction for health insurance expenses of self-employed individuals. About 60,000 of these taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 120,000 persons would be newly insured as a result of the 100-percent deduction for health insurance expenses.

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JOINT COMMITTEE ON TAXATION
Washington, DC 20515-6453

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United States Senate

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We do not have an estimate of the number of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

I hope this information is helpful to you. If we can be of further assistance, please let me know.

Sincerely,


Lindy L. Paull

Enclosure: Table #99-3 206

- Senator Kennedy -
 ESTIMATED REVENUE EFFECTS OF VARIOUS PROVISIONS RELATING TO HEALTH CARE

Fiscal Years 2000 - 2009

(Millions of Dollars)

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
Health Care Provisions in the Conference Agreement for H.R. 2488													
1. Provide an above-the-line deduction for health insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	--	--	-444	-1,379	-1,477	-1,808	-3,137	-5,878	-8,299	-8,848	-3,300	-31,254
2. Provide an above-the-line deduction for long-term care insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	--	--	-48	-328	-364	-417	-677	-1,915	-2,027	-2,148	-741	-7,321
3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1]	tyba 12/31/01	--	--	-104	-151	-171	-190	-202	-204	-215	-247	-428	-1,487
Total of Health Care Provisions in the Conference Agreement for H.R. 2488		--	--	-596	-1,858	-2,012	-2,410	-4,016	-7,397	-10,541	-11,241	-4,467	-40,072
Health Care Provisions in S. 1344, as passed by the Senate													
1. Immediate 100% deductibility of health insurance and long-term care insurance premiums for the self-employed	tyba 12/31/99	-245	-1,007	-1,040	-657	--	--	--	--	--	--	-2,848	-2,84
2. Liberalization of conditions for enrolling in MSAs	tyba 12/31/99	-83	-281	-328	-370	-414	-458	-502	-548	-590	-634	-1,483	-4,21
Total of Health Care Provisions in S. 1344, as passed by the Senate		-328	-1,288	-1,368	-1,027	-414	-458	-502	-548	-590	-634	-4,432	-7,16

Joint Committee on Taxation

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Legend for "Effective" column: tyba = taxable years beginning after

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108TH CONGRESS, 1ST SESSION

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Congress of the United States

JOINT COMMITTEE ON TAXATION

1015 LONGWORTH HOUSE OFFICE BUILDING

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The conference agreement on H.R. 2488 also contains a provision that would allow long-term care insurance to be offered as part of cafeteria plans, effective for taxable years beginning after December 31, 2001.

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We do not have an estimate of the number of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

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Sincerely,


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Fiscal Years 2000 - 2009

(Millions of Dollars)

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
Health Care Provisions in the Conference Agreement for H.R. 2498													
1. Provide an above-the-line deduction for health insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	--	--	-444	-1,379	-1,477	-1,808	-3,137	-5,878	-8,299	-8,848	-3,300	-31,254
2. Provide an above-the-line deduction for long-term care insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	--	--	-48	-328	-364	-417	-877	-1,315	-2,027	-2,148	-741	-7,321
3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1]	tyba 12/31/01	--	--	-104	-151	-171	-190	-202	-204	-215	-247	-428	-1,468
Total of Health Care Provisions in the Conference Agreement for H.R. 2498		--	--	-596	-1,858	-2,012	-2,410	-4,016	-7,397	-10,541	-11,241	-4,467	-40,043
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2. Liberalization of conditions for enrolling in MSAs	tyba 12/31/99	-83	-291	-328	-370	-414	-458	-502	-546	-590	-634	-1,483	-4,21
Total of Health Care Provisions in S. 1344, as passed by the Senate		-328	-1,298	-1,368	-1,027	-414	-458	-502	-546	-590	-634	-4,432	-7,16

Joint Committee on Taxation

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Congress of the United States

JOINT COMMITTEE ON TAXATION
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Congress of the United States

JOINT COMMITTEE ON TAXATION

Washington, DC 20515-6453

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United States Senate

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We do not have an estimate of the number of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

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Lindy L. Paull

Enclosure: Table #99-3 206

Fiscal Years 2000 - 2009

2022250832

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Legend for "Effective" column: tyba = taxable years beginning after

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 7, 1999
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 2723 - Bipartisan Consensus Managed Care Improvement Act of 1999

(Reps. Norwood (R) GA and Dingell (D) MI and 132 cosponsors)

The President strongly supports the enactment of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. This bipartisan legislation would provide new patient protections to all Americans in all health plans, and hold health plans accountable when their actions cause harm to patients.

Since 1997, when he received the report of his Quality Commission, the President has been calling on the Congress to pass a strong, enforceable, and bipartisan Patients' Bill of Rights. In the absence of congressional action, the President directed the Federal health plans, covering over 85 million Americans, to implement the patient protections recommended by the Commission. Many States have also passed legislation providing important protections to their residents, including requiring new protections for patients in emergency situations, establishing access to independent external appeals processes, and ensuring access to specialists.

While these actions are important, the limits on State jurisdiction and Federal regulatory authority make it impossible to ensure that all Americans in all health plans have the protections they need. States do not have the authority to regulate self-insured plans, leaving almost 50 million people unprotected nationwide. Moreover, current enforcement limitations under Federal law frequently preempt State law even for those plans regulated by the States.

Adoption of any substitute amendment other than Norwood-Dingell will demonstrate that this Congress is not serious about responding to the public's need for protection in the Nation's ever-changing health care delivery system. The President is strongly committed to working with Members of both parties to pass a meaningful Patients' Bill of Rights this year; he is equally committed, however, to vetoing any legislation that is a Patients' Bill of Rights in name only.

On August 5, 1999, the President commended Representatives Norwood, Dingell, and Ganske for their leadership in introducing a strong, enforceable Patients' Bill of Rights. He endorsed H.R. 2723 because it provides meaningful patient protections, such as the right to emergency care wherever and whenever a medical emergency arises; the right to access the health care specialists that a patient needs; the right to ensure care is not disrupted during treatment; the right to an unbiased internal appeals process and an independent external appeals process that allows patients to get the care they were promised; and the right to hold health plans accountable for actions that harm patients.

The Administration strongly opposes the amendments in the nature of a substitute to H.R. 2723. These amendments that were made in order by the Rules Committee would weaken key provisions of the bill and are designed solely to undermine the enforcement provisions contained in H.R. 2723. If these substitute amendments are adopted and presented to the President, his senior advisors would recommend that he veto the bill.

The Boehner amendment scheduled to be offered today provides clearly inadequate protections and does not even extend those protections to all Americans in all plans. Since the limited protections only apply to employer sponsored plans, at least 15 million Americans would not be covered under this legislation. Moreover, the patient protections fall short in numerous areas, including: no requirement to assure access to specialists when a plan's provider network is inadequate; allows plans to provide excessive financial incentives to providers to limit medically necessary care; and requires parents of newborns to receive prior approval before receiving emergency care. Finally, there are absolutely no individual remedies that can be accessed through the courts to hold plans accountable for actions that have harmed patients.

While the Coburn/Shadegg amendment offers some additional protections, such provisions are far too weak. The legislation is unacceptably flawed in numerous areas, including:

Newborns would not be provided the same access to emergency care protections as provided to adults. Parents would need to receive prior approval to be sure they can be reimbursed for emergency care services for their children.

No protections against plans limiting access to necessary medications. This bill allows plans to deny coverage of prescription drugs that are not part of the plan's drug formulary even when prescribed by health care providers and determined to be medically necessary.

An external review process that is biased against low-income patients. All patients, even if they are unable to afford it, must pay a \$25 filing fee to have their case considered by an external review entity. If the patient cannot pay the filing fee, the appeals entity will not hear their case.

Meaningless information disclosure requirements that leave patients in the dark about their rights. Plans are not required to inform enrollees of their limited new rights. Moreover, plans may meet their information disclosure requirements by providing patients with technical billing and diagnostic codes, which are intended for use by health care professionals, not patients.

A flawed enforcement provision that severely limits patients ability to hold plans accountable. Under the Coburn/Shadegg amendment, the roadblocks to accessing court based remedies include:

- Imposing a health care cost cap that must be exceeded to sue or even appeal a harmful plan decision. Under this provision, a woman who was denied a mammography and subsequently had her cancer spread would not be able to sue the plan let alone appeal the original denial of service.

- Requiring patients who have already been harmed to exhaust all levels of appeals before seeking redress. Under this provision, a patient who by any definition has been injured as a result of a plan decision must go through an unnecessarily time consuming appeals process even though the outcome is clear.
- Requiring time consuming and burdensome certification in order for a patient injured by a plan decision to file a case. This requirement may be without precedent, and it certainly implements an extraordinary hurdle for enrollees seeking redress.

Enacting meaningful Patients' Bill of Rights legislation is long overdue. The President strongly urges the House to pass a "clean" H.R. 2723, which enjoys broad bipartisan support, and give all Americans the health care protections they need and deserve.

As the President has already indicated in a letter, the Administration remains very concerned about the Rule that was approved for H.R. 2723 because it prohibited the consideration of revenue measures in support of H.R. 2723, many of which were passed by the House in other legislation.

* * * * *



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 7, 1999
(House)

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- Requiring time consuming and burdensome certification in order for a patient injured by a plan decision to file a case. This requirement may be without precedent, and it certainly implements an extraordinary hurdle for enrollees seeking redress.

Enacting meaningful Patients' Bill of Rights legislation is long overdue. The President strongly urges the House to pass a "clean" H.R. 2723, which enjoys broad bipartisan support, and give all Americans the health care protections they need and deserve.

As the President has already indicated in a letter, the Administration remains very concerned about the Rule that was approved for H.R. 2723 because it prohibited the consideration of revenue measures in support of H.R. 2723, many of which were passed by the House in other legislation.

* * * * *



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 7, 1999
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 2723 - Bipartisan Consensus Managed Care Improvement Act of 1999

(Reps. Norwood (R) GA and Dingell (D) MI and 132 cosponsors)

The President strongly supports the enactment of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. This bipartisan legislation would provide new patient protections to all Americans in all health plans, and hold health plans accountable when their actions cause harm to patients.

Since 1997, when he received the report of his Quality Commission, the President has been calling on the Congress to pass a strong, enforceable, and bipartisan Patients' Bill of Rights. In the absence of congressional action, the President directed the Federal health plans, covering over 85 million Americans, to implement the patient protections recommended by the Commission. Many States have also passed legislation providing important protections to their residents, including requiring new protections for patients in emergency situations, establishing access to independent external appeals processes, and ensuring access to specialists.

While these actions are important, the limits on State jurisdiction and Federal regulatory authority make it impossible to ensure that all Americans in all health plans have the protections they need. States do not have the authority to regulate self-insured plans, leaving almost 50 million people unprotected nationwide. Moreover, current enforcement limitations under Federal law frequently preempt State law even for those plans regulated by the States.

Adoption of any substitute amendment other than Norwood-Dingell will demonstrate that this Congress is not serious about responding to the public's need for protection in the Nation's ever-changing health care delivery system. The President is strongly committed to working with Members of both parties to pass a meaningful Patients' Bill of Rights this year; he is equally committed, however, to vetoing any legislation that is a Patients' Bill of Rights in name only.

On August 5, 1999, the President commended Representatives Norwood, Dingell, and Ganske for their leadership in introducing a strong, enforceable Patients' Bill of Rights. He endorsed H.R. 2723 because it provides meaningful patient protections, such as the right to emergency care wherever and whenever a medical emergency arises; the right to access the health care specialists that a patient needs; the right to ensure care is not disrupted during treatment; the right to an unbiased internal appeals process and an independent external appeals process that allows patients to get the care they were promised; and the right to hold health plans accountable for actions that harm patients.

The Administration strongly opposes the amendments in the nature of a substitute to H.R. 2723. These amendments that were made in order by the Rules Committee would weaken key provisions of the bill and are designed solely to undermine the enforcement provisions contained in H.R. 2723. If these substitute amendments are adopted and presented to the President, his senior advisors would recommend that he veto the bill.

The Boehner amendment scheduled to be offered today provides clearly inadequate protections and does not even extend those protections to all Americans in all plans. Since the limited protections only apply to employer sponsored plans, at least 15 million Americans would not be covered under this legislation. Moreover, the patient protections fall short in numerous areas, including: no requirement to assure access to specialists when a plan's provider network is inadequate; allows plans to provide excessive financial incentives to providers to limit medically necessary care; and requires parents of newborns to receive prior approval before receiving emergency care. Finally, there are absolutely no individual remedies that can be accessed through the courts to hold plans accountable for actions that have harmed patients.

While the Coburn/Shadegg amendment offers some additional protections, such provisions are far too weak. The legislation is unacceptably flawed in numerous areas, including:

Newborns would not be provided the same access to emergency care protections as provided to adults. Parents would need to receive prior approval to be sure they can be reimbursed for emergency care services for their children.

No protections against plans limiting access to necessary medications. This bill allows plans to deny coverage of prescription drugs that are not part of the plan's drug formulary even when prescribed by health care providers and determined to be medically necessary.

An external review process that is biased against low-income patients. All patients, even if they are unable to afford it, must pay a \$25 filing fee to have their case considered by an external review entity. If the patient cannot pay the filing fee, the appeals entity will not hear their case.

Meaningless information disclosure requirements that leave patients in the dark about their rights. Plans are not required to inform enrollees of their limited new rights. Moreover, plans may meet their information disclosure requirements by providing patients with technical billing and diagnostic codes, which are intended for use by health care professionals, not patients.

A flawed enforcement provision that severely limits patients ability to hold plans accountable. Under the Coburn/Shadegg amendment, the roadblocks to accessing court based remedies include:

- Imposing a health care cost cap that must be exceeded to sue or even appeal a harmful plan decision. Under this provision, a woman who was denied a mammography and subsequently had her cancer spread would not be able to sue the plan let alone appeal the original denial of service.

- Requiring patients who have already been harmed to exhaust all levels of appeals before seeking redress. Under this provision, a patient who by any definition has been injured as a result of a plan decision must go through an unnecessarily time consuming appeals process even though the outcome is clear.
- Requiring time consuming and burdensome certification in order for a patient injured by a plan decision to file a case. This requirement may be without precedent, and it certainly implements an extraordinary hurdle for enrollees seeking redress.

Enacting meaningful Patients' Bill of Rights legislation is long overdue. The President strongly urges the House to pass a "clean" H.R. 2723, which enjoys broad bipartisan support, and give all Americans the health care protections they need and deserve.

As the President has already indicated in a letter, the Administration remains very concerned about the Rule that was approved for H.R. 2723 because it prohibited the consideration of revenue measures in support of H.R. 2723, many of which were passed by the House in other legislation.

* * * * *

American Medical Association

Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005**FAX TRANSMISSION SHEET**Date: 10/1/99To: Barbara Woolley
Chris JenningsFrom: Richard A. Deem
Vice President
Government Affairs
Tel: (202)789-7413

Message:

These ads will run in the Washington
Post, Roll Call & USA Today next week.

Total Pages (including cover sheet):

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Government Affairs



The Texas Model: Rx for Success

In 1997, Texas became the first state to pass a law holding HMOs accountable for their actions. Governor George W. Bush allowed the bill to become Texas law.

What happened?

"'The sky didn't fall,' said state Sen. David Sibley, a Republican who was the law's main champion in the Texas legislature. 'Those horror stories' raised by the industry 'just did not transpire.'..."

"Sibley, the bill's main sponsor, is a lawyer, a former doctor and an ally of Gov. George W. Bush (R)...."

"That spring, the bill passed with overwhelming support from both political parties... Two years later, a Bush spokesman said the governor believes the law has 'worked well.'"

— Washington Post, 9/28/99

Patients' rights works for Texans. And patients' rights will work for Americans, too. Norwood-Dingell is the real "patients' bill of rights" ...for all Americans.

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MENT AFFAIRS C JENNINGS : 202 789 4692 # 3/ 3

There's a rights way. And a wrong way.

Should doctors make medical decisions? Should you have the right to hold your health plan accountable when negligence harms you? These will be big issues this week when the House votes on a patients' bill of rights.

Opponents claim your rights will lead to countless lawsuits, which would cause rates to rise, and make care too costly.

But it's not true. Patients in Texas have the right to sue, and guess what? Even the state's HMO trade group admitted that no health plan had to raise premiums. Lawsuits haven't skyrocketed. In fact, four million Texans belong to HMOs and only five have sued.

The bipartisan Norwood-Dingell bill will give physicians final say on medical decisions. Allow you to appeal your health plan's treatment decisions to an independent review board. And guarantee your right to sue. Passing this bill is the right thing to do.

Protecting patients' rights is crucial. But just as crucial is the effort to improve the health care system on all fronts so it works better for everyone.

We believe the answer lies in one simple question.

It's a question that can quickly bring focus to the debate. It can establish common ground. And be an invaluable guide in designing effective new proposals, be they local, corporate or national.

Conclusion? Whenever health care is the issue, this should be the only real question: **Is it good medicine?**

American Medical Association

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Find out what physicians of the AMA have to say on issues important to you and your doctor at www.ama-assn.org/grassroots

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210



DATE: 10/5

Devora

TO: Chris Jennings / Gary Claxton
(Name)

(Company)

(Room/Suite #)

456-5557 / 401-7321
(Phone #) (Fax #)

FROM:

DAN MAGUIRE / Kaye Pestaina
U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Avenue, N.W. - Room N5677
Washington, D.C. 20210

TOTAL NUMBER OF PAGES, INCLUDING THIS PAGE: 2

MY FAX NUMBER: (202) 219-6531

FOR CONFIRMATION: (202) 219-9044

COMMENTS:

Attached is the info on FZHB. We are
also sending this to Bridget & Amy.



October 23, 1998

STATEMENT BY THE PRESIDENT

THE WHITE HOUSE

Office of the Press Secretary

**For Immediate Release
October 23, 1998**

STATEMENT BY THE PRESIDENT

The Federal Employees Health Care Protection Act of 1998, H.R. 1836, that I have signed into law makes several critical improvements to the Federal Employees Health Benefits Program (FEHBP). For example, it gives the Office of Personnel Management's Inspector General critical new debarment authority to crack down on fraud-u-lent providers and, when necessary, to debar those who defraud the program; it contains essential new provisions to maintain and improve consumer choice, the hallmark of FEHBP, by allowing fee-for-service plans to rejoin FEHBP; it makes health care more affordable for certain Federal employees and retirees of the Federal Deposit Insurance Corporation and the Federal Reserve Board by allowing them to participate in the FEHBP; and finally, it ensures that certain Federal physicians who provide high quality services will receive appropriate compensation for their services, which is critical to attracting and maintaining a high quality Federal physician work force.

I want to note, however, my objection to a provision in this legislation that appears to expand preemption of State law remedies for FEHBP enrollees who are injured as a result of wrongful benefit delay or denial by their plan. As I have consistently stated, I believe that a right without remedy is not a right at all. I strongly believe that Federal employees should have the right to legally enforce-able remedies, including under State law, to protect them when health plans do not provide contractually obligated patient protections. I therefore want to clarify that my enactment of this legislation should in no way be construed to indicate my support for this preemption provision. I also would like to reiterate my disappointment that the Congress has adjourned without passing a Patients' Bill of Rights that would give new protections and remedies to all Americans, including Federal employees. Assuring that health plans provide needed patient protections and adequate remedies will be one of my top priorities for the next Congress.

WILLIAM J. CLINTON

**THE WHITE HOUSE,
October 23, 1998.**

30-30-30

UNITED STATES SENATE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
WASHINGTON, DC 20510-6300

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DATE

10/6

TO

Chris Jennings

FAX NUMBER

456-5557

FROM

DAVID NEXON / JACKIE
(202) 224-7675 phone
(202) 224-3533 fax

NUMBER OF PAGES

6

(including cover)

MESSAGE

Please deliver ASAP.
Thank you.

To: Bridgett Taylor

From: David

Date: October 6, 1999

Re: New Joint Tax estimates: Tax breaks in Republican "Access" Package will result in minimal increases in coverage

Joint Tax has estimated the proportion of currently uninsured who would benefit from the tax breaks in the Republican bill. It is clear that the impact on the 44 million uninsured would be minimal. Virtually all benefits will go to currently insured individuals, and the total number of the uninsured benefitting is tiny.

PROVISION	TOTAL BENEFITTING UNINSURED BENEFITTING		%
General deductibility	9.1 million	200,000	2
Self-employed	3.3 million	60,000	1.8
MSAs	N/A	N/A	N/a

cc: Gerry, Carey, Will, Jim, Michael, Stephanie

105TH CONGRESS, 1ST SESSION

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Congress of the United States

JOINT COMMITTEE ON TAXATION

1015 LONGWORTH HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-6433

(202) 225-3621

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OCT 06 1999

Honorable Edward M. Kennedy
United States Senate
SR-315
Washington, DC 20510

Dear Senator Kennedy:

This is in response to your letter of October 4, 1999, requesting revenue estimates and other information concerning several of the health care tax provisions in the conference agreement on H.R. 2488 and two of the health care tax provisions in S. 1344.

The conference agreement on H.R. 2488 contains an above-the-line deduction for health insurance expenses and long-term care insurance expenses for which the taxpayer pays at least 50 percent of the premium. The deduction would be phased in at 25 percent for taxable years beginning in 2002 through 2004, 35 percent for taxable years beginning in 2005, 65 percent for taxable years beginning in 2006, and 100 percent for taxable years beginning in 2007 and thereafter. Taxpayers enrolled in Medicare, Medicaid, Champus, VA, the Indian Health Service, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program would be ineligible for the deduction for health insurance expenses.

The conference agreement on H.R. 2488 also contains a provision that would allow long-term care insurance to be offered as part of cafeteria plans, effective for taxable years beginning after December 31, 2001.

For the purpose of preparing revenue estimates for these provisions in H.R. 2488, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2002 about 9.1 million taxpayers would claim the 25-percent deduction for health insurance expenses. About 100,000 of these 9 million taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 200,000 persons would be newly insured as a result of the 25-percent deduction for health insurance expenses.

We estimate that in calendar year 2002 about 4.7 million taxpayers would claim the 25-percent deduction for long-term care insurance expenses, and an additional 300,000 taxpayers

Congress of the United States
JOINT COMMITTEE ON TAXATION
Washington, DC 20515-6453

Honorable Edward M. Kennedy
United States Senate

Page 2

would use cafeteria plans to pay their share of premiums for employer-sponsored long-term care insurance. About 80,000 of these 5 million taxpayers would be new purchasers of long-term care insurance.

S. 1344 contains a provision that would increase the deduction for health insurance expenses of self-employed individuals. Under present law, when certain requirements are satisfied, self-employed individuals are permitted to deduct 60 percent of their expenditures on health insurance and long-term care insurance. The deduction is scheduled to increase to 70 percent of such expenses for taxable years beginning in 2002 and 100 percent in all taxable years beginning thereafter. S. 1344 would increase the rate of deduction to 100 percent of health insurance and long-term care insurance expenses for taxable years beginning after December 31, 1999.

S. 1344 also contains provisions that would eliminate certain restrictions on the availability of medical savings accounts, remove the limitation on the number of taxpayers that are permitted to have medical savings accounts, reduce the minimum annual deductibles for high-deductible health plans to \$1,000 for plans providing single coverage and \$2,000 for plans providing family coverage, increase the medical savings account contribution limit to 100 percent of the annual deductible for the associated high-deductible health plan, limit the additional tax on distributions not used for qualified medical expenses, and allow network-based manage care plans to be high-deductible plans. These provisions would be effective for taxable years beginning after December 31, 1999.

For the purpose of preparing revenue estimates for these provisions in S. 1344, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2000, about 3.3 million taxpayers would claim the 100-percent deduction for health insurance expenses of self-employed individuals. About 60,000 of these taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 120,000 persons would be newly insured as a result of the 100-percent deduction for health insurance expenses.

Congress of the United States
JOINT COMMITTEE ON TAXATION
Washington, DC 20515-6453

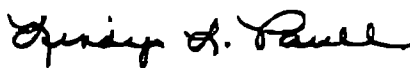
Honorable Edward M. Kennedy
United States Senate

Page 3

We do not have an estimate of the number of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

I hope this information is helpful to you. If we can be of further assistance, please let me know.

Sincerely,


Lindy L. Paull

Enclosure: Table #99-3 206

- Senator Kennedy -
ESTIMATED REVENUE EFFECTS OF VARIOUS PROVISIONS RELATING TO HEALTH CARE

Fiscal Years 2000 - 2009

(Millions of Dollars)

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
Health Care Provisions in the Conference Agreement for H.R. 2488													
1. Provide an above-the-line deduction for health insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	--	--	-444	-1,379	-1,477	-1,808	-3,187	-5,878	-8,299	-8,848	-3,300	-31,264
2. Provide an above-the-line deduction for long-term care insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	--	--	-48	-328	-364	-417	-677	-1,315	-2,027	-2,148	-741	-7,322
3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1]	tyba 12/31/01	--	--	-104	-161	-171	-190	-202	-204	-215	-247	-426	-1,487
Total of Health Care Provisions in the Conference Agreement for H.R. 2488		--	--	-596	-1,858	-2,012	-2,410	-4,016	-7,397	-10,541	-11,241	-4,467	-40,073
Health Care Provisions in S. 1344, as passed by the Senate													
1. Immediate 100% deductibility of health insurance and long-term care insurance premiums for the self-employed	tyba 12/31/99	-245	-1,007	-1,040	-657	--	--	--	--	--	--	-2,948	-2,84
2. Liberalization of conditions for enrolling in MSAs	tyba 12/31/99	-83	-281	-328	-370	-414	-459	-502	-546	-590	-634	-1,483	-4,21
Total of Health Care Provisions in S. 1344, as passed by the Senate		-328	-1,288	-1,368	-1,027	-414	-459	-502	-546	-590	-634	-4,432	-7,16

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column: tyba = taxable years beginning after

[1] Estimate assumes concurrent enactment of the above-the-line deduction for long-term care insurance (Item 2.).

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