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S. 1936, THE CHAFEE BILL: A STEP TOWARD HEALTH CARE REFORM

INTRODUCTION

That America's health care system urgently needs reform has become a Washington truism. The debate is over what kind of reform.

Last month, Senate Republicans added their voices to this debate with legislation introduced by Senator John Chafee of Rhode Island, and co-sponsored by twenty of his Republican colleagues. Entitled "The Health Equity and Access Improvement Act of 1991" (S. 1936), the Chafee bill is the product of more than a year's work by a Senate Republican task force on health care. As a major contribution to the health care debate, the bill could serve as the foundation for a health care system that gives all Americans access to health care and that is based on the principle of consumer choice.

The most important feature of the Chafee proposal is its change in the federal tax treatment of health insurance purchases. Specifically, the bill calls for tax credits and deductions to help uninsured Americans, the self-employed, and small businesses to purchase medical care and health insurance, and to encourage all Americans to obtain preventive medical services.

Beyond these key tax-related provisions, the Chafee bill:

- **Expands** federal government health care programs to assist low-income families and urban and rural areas facing shortages of medical personnel and facilities;
- **Reforms** health insurance regulations and practices;
- **Increases** the authority of states to launch demonstration projects in health care delivery and financing by permitting the states to apply for waivers from federal employee benefit laws and from federal requirements pertaining to government health programs like Medicare, Medicaid, and Public Health Service Grants; and

- **Reforms** medical liability laws.

Estimates of the cost of the bill are not yet available. Nor is every wrinkle removed from the bill. Said Chafee candidly when introducing the legislation: "We invite refinement and improvement—the proposal is certainly not set in stone." Yet even in its current form, the Chafee bill is an important and valuable contribution to the health care reform debate.

What distinguishes the Chafee bill from other major health care bills introduced this year is that it is a significant attempt by lawmakers to address problems relating to the dominant role played by federal tax policy in America's health system. Most of the critical problems plaguing America's health care financing system can be traced to three distressing features of the existing system, which gives the most generous tax breaks to workers with employer-sponsored health insurance:

1) **Changing employment often means workers lose their health benefits;**

2) **Workers without company health benefits usually receive no tax help to buy their own coverage; and**

3) **The illusion that company-paid benefits are free discourages workers from being economical in their purchases of health care.**

The Chafee bill begins to correct some of those defects in the current system.

The bill also contains the most sweeping proposal yet offered in Congress for allowing the states to become laboratories for innovative health policies. This is commendable, and if enacted would lead to a surge of state-based experimentation with health care reforms.

Much less desirable are the Chafee bill's provisions relating to medical liability law and insurance regulation. While addressing genuine problems, the provisions raise significant issues relating to the proper division of authority between state and federal governments. To their credit, the bill's sponsors admit such federalism problems. But the provisions also raise practical problems and would trigger more government spending on health care.[1]

The Chafee reform legislation would be improved if its tax provisions were simplified. As drafted, the bill creates two new tax credits and one new deduction for individuals, while eliminating an existing tax credit. The bill also creates four new tax credits for businesses and expands the existing tax deduction for the self-employed. The net result would be to increase the total number of federal health-related tax breaks from four to ten.

1 Some of these other provisions will be examined in greater detail in a forthcoming study on insurance reform bills pending in Congress.

Much simpler and more effective than this patchwork of tax measures would be a single health care tax credit for all medical care and health insurance. The credit would be granted to all taxpayers with the amount of the credit being a percentage of the household's total health expenses. This percentage would vary according to the relationship between a household's total health expenses and its income. The larger a share of income a household spends on health care, the larger the credit. This credit, moreover, would be refundable. This means that if the amount of the credit exceeds the amount of a family's income tax liability, the government would pay the family the difference.

Such a single credit, proposed by Heritage Foundation scholars, could replace all existing health care tax breaks.[2] By far the biggest of these tax breaks is the "tax exclusion" for employer-sponsored health insurance. This tax exclusion means that the value of a worker's employer-sponsored health benefits is not counted as income to the worker. Thus, excluding those benefits from a worker's taxable income means that the employee pays no income or payroll taxes on the portion of his wages used to purchase employer-sponsored health coverage.

Seeking Better Value. Limiting, or phasing out entirely, the tax exclusion would free up the funds needed to finance any new system of health care tax credits. Americans would receive the same, total amount of tax relief on health expenses they now enjoy, but in a different form. Thus, the government would neither gain nor lose revenue, making the changes "budget neutral." In the case of S.1936, such a reform would create the financing mechanism for the bill's new tax breaks, which is so glaringly absent from the legislation in its present form. Limiting the exclusion also would have the advantage of encouraging workers to seek better value for money in employer-sponsored health plans—something most workers have little or no incentive to do today.

A single credit in place of today's tax breaks would have a number of advantages:

- It would target assistance to those in greatest need, particularly those unable to obtain traditional employment-based health insurance;
- It would eliminate the existing disparities between the tax treatment of money spent directly on medical care and money spent on health insurance;
- It would expand consumer choice dramatically by removing the heavy tax penalty on purchasing health insurance and medical care other than through an employer-sponsored plan; and, most important
- It would give consumers direct control over the funds used to purchase health care, and thus would force medical providers and health insurers to respond to consumer demands by offering better quality medical services and insurance plans at lower prices.

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2 See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); and Stuart M. Butler, "A Tax Reform Strategy to Deal with the Uninsured," *Journal of the American Medical Association*, Vol. 265, May 15, 1991.

Most of the health reform proposals introduced so far in Congress would rely on government officials or company executives to manage the health care system. But neither government-controlled national health systems nor legally imposed mandates on employers to provide health coverage use consumer choice as the principal instrument to control costs while assuring efficiency.

Chafee's S. 1936 is a promising basis for reform because it recognizes both that consumer choice has the power to improve efficiency and that the current tax treatment of health care suffocates or distorts consumer choice. With suitable revisions, the bill thus could be the foundation for a universal, consumer-choice health system for America.

THE PROBLEMS OF CURRENT HEALTH CARE TAX POLICY

The chief virtue of the bill proposed by Chafee and his Senate colleagues is that it recognizes that the underlying causes of America's health care financing crisis can be traced to the profoundly distorting effects of federal health care tax policy.

Federal law currently allows four different tax breaks for health expenses.

1) The Federal Tax Exclusion.

By far the biggest and most important of these tax breaks for health care is the tax-free status of employer-sponsored health benefits. The money spent by an employer on a worker's health benefits is really part of the worker's wages. But the government does not count this money as taxable income to the worker, who thus avoids paying income or payroll taxes on it. This is known as a tax exclusion. Meaning: the portion of a worker's wages received in the form of employer-sponsored health benefits specifically is excluded by the IRS from all taxation.

Federal definitions of taxable income, moreover, generally are the definitions used for state taxation. Thus the exclusion also is a tax break at the state level. Taken together, the total amount of tax relief at all levels of government made possible by this tax exclusion will be about $60 billion in fiscal 1992.

It should be stressed that this policy of excluding from a worker's taxable income the value of any employer-sponsored health benefits he or she receives is not the same thing as the employer deducting the cost of those same benefits from its corporate income taxes. These are two different tax provisions which apply to the same money. From an employer's corporate tax perspective, it makes little difference whether workers are paid with cash wages or in-kind benefits. Both are business expenses and thus both are deducted from a firm's gross revenues when determining how much tax the firm is to pay. Companies pay corporate income tax only on the remaining net profit. Firms, therefore, get no special benefit by giving employees medical coverage instead of giving them higher cash wages. Conversely, firms will not be hurt by paying employees higher cash wages in place of medical coverage.

2) The Medical Expense Tax Deduction.

Taxpayers may deduct from their income tax some of the money they spend directly on buying either medical services or health insurance, but can do this only if they meet two restrictive conditions. First, their total tax deductions must exceed the standard deduction, which in 1991 is $3,400 for a single taxpayer and $5,700 for a family. This allows them to itemize their tax deductions on their tax return. If they can itemize, then they encounter the second restrictive condition: they can deduct only those health expenses that exceed 7.5 percent of their gross income. Few Americans, understandably, benefit from this tax break and those who do receive relatively little tax relief compared to their total health expenses. The total amount of tax relief provided through this tax deduction is projected to be $2.9 billion in fiscal year 1992.

3) Tax Deduction for the Self-Employed.

Self-employed individuals are not eligible for the medical insurance tax exclusion unless they are incorporated. Instead, they may deduct from their taxable income 25 percent of the money they spend on health insurance premiums for themselves and their families. As a result, the self-employed enjoy substantially less tax relief on their health expenses than do workers with employer-sponsored health benefits.

The self-employed in effect pay income taxes on 75 percent of the money used to buy their health insurance, and pay Social Security taxes on 100 percent of that money (since the deduction is calculated only after Social Security taxes are paid). In contrast, workers with employer-sponsored benefits pay the IRS nothing in either personal income or payroll taxes on the money spent on their health benefits. The tax law provision allowing this 25 percent deduction for health insurance purchased by the self-employed was scheduled to expire at the end of this year, but Congress renewed it for one more year. The total amount of tax relief granted through this tax deduction is projected to be just $100 million in fiscal year 1992.

4) The Health Care EITC.

A new health insurance tax credit was added to the existing Earned Income Tax Credit (EITC) for low-income workers by the 1990 Omnibus Budget Reconciliation Act. The EITC is a special tax credit available only to low-income workers, and has the effect of boosting after-tax income for the working poor. Authored by Senator Lloyd Bentsen, the Texas Democrat and Chairman of the Senate Finance Committee, this is an important reform because it directly helps working Americans not covered by company health plans.

The credit can be claimed for money spent by a low-income family on health insurance, as long as the insurance coverage includes one or more dependent children not covered under a company plan. The credit is limited to the lesser of the maximum allowable credit (which is $428) or the actual amount spent by the taxpayer on health insurance coverage for dependent children not covered under a company plan. In 1991, the tax credit is equal to 6 percent of the taxpayer's

earned income up to $7,140, and is refundable. For eligible taxpayers with incomes of $11,250 or more, the maximum credit gradually is reduced until it is eliminated entirely for taxpayers with incomes above $21,250. The total amount of tax relief provided through this tax deduction is small, projected to be $600 million in fiscal 1992.

THE PERVERSE INCENTIVES OF THE TAX EXCLUSION

In combination, these tax policies offer most working Americans and their families very generous tax relief on their medical expenses, but only on two very restrictive conditions. First, they must purchase their medical care through health insurance. Second, they must purchase their health insurance through their employer.

This structure of tax relief, particularly the tax exclusion for employer-sponsored health benefits, creates powerful and perverse economic incentives within the health care market. These incentives increase costs and are largely responsible for the high degree of uninsurance among families lacking company-sponsored health benefits.

Because of the tax treatment, there is little or no incentive for Americans to hold down their health care costs. For example, in many cases it would be better and cheaper for workers and their families to purchase low-cost or routine medical care directly out-of-pocket, or to buy a health insurance plan other than the one offered by the employer. But under the current system, workers who buy medical care directly or who choose a plan other than that offered by their employer are heavily penalized by losing most, or all, federal tax relief for their medical expenses.

No Reward for Economizing. In general, a worker with employer-sponsored health insurance has little incentive to be cost conscious because he or she cannot normally pocket any significant savings from economizing on unnecessary care or from seeking quality care at lower prices. At the same time, a doctor, hospital, or clinic that offers good quality at lower prices is not rewarded with more patients and thus more income. This is simply because patients rarely seek out such good value since, in most cases, they are paying little or nothing for these services or for the insurance to cover the services. Instead, doctors and hospitals who dispense more services, even if their actual benefit to the patient is marginal, or who charge higher prices, meet with little resistance from patients who in general take the view that "my company is paying."

Even worse, those who most need help in paying for medical care or health insurance receive little or nothing in tax relief. Most of the current tax relief goes to well-paid workers with generous employer-sponsored health benefits. Those without employer-sponsored coverage—the self-employed, many low-wage or part-time workers, or employees of small businesses without health plans—receive little or no tax relief for their medical care and insurance.

In terms that economists use, the current tax relief of employer-provided insurance is sharply regressive. While most Americans view health insurance as a social good that ought to be given favorable tax treatment, the current tax system

treats it in a way that gives huge benefits to high-income enrollees of employer-based insurance, because these individuals are in the highest tax brackets. Lower income families are not as fortunate. In fact, of the approximately $64 billion a year in health care tax relief, about $33 billion, or just over half, goes to families with annual incomes of $50,000 or more and about 25 percent of the tax benefits go to families with incomes above $75,000. By contrast, less than $5 billion, or 8 percent of the total, goes to families with incomes below $20,000 a year. And most families without company plans receive no tax benefits at all when they buy health insurance or medical services.

Tied to the Work Place. Furthermore, tax provisions that benefit mainly company-provided health plans make access to health benefits contingent on the place of work. When a worker thus moves from one job to another or is temporarily unemployed, the worker and his or her family almost always lose their health insurance. Yet they do not suddenly lose their life insurance, or their homeowners insurance, or their car insurance; these insurance policies have nothing to do with the place of work. But the person changing jobs or out of work must try to requalify under the new company's health insurance plan or buy his or her own insurance if their new employer does not offer an adequate plan. If the family has a history of poor health, it even may not qualify for a new plan.

Given how tax policies discourage cost control and give least help to those facing the biggest need, it is not surprising that over 30 million Americans have no health insurance coverage whatsoever and that the largest element of the uninsured are workers and the dependents of workers. Not only do these tax policies produce winners and losers, but they doubly penalize the losers. First, the tax policies create perverse incentives in the health care marketplace which drive up the cost of medical care and health insurance much faster than the costs of most other goods and services. The result is that those workers and their families who live on the economic margins, such as low-wage or part-time workers, the self-employed, or employees of small businesses, simply are priced out of the market. Second, the tax policies hit these same individuals and families yet again by giving them virtually no health care tax relief, though they are the very ones who need such help the most.

It is such inequities and inefficiencies in the current tax system that the Chafee bill attempts to eliminate.

THE TAX CHANGES IN S. 1936

S. 1936 contains several important provisions, ranging from its reform of medical liability laws to steps to permit more widespread health policy experimentation by states. Some of these provisions would improve health care in America; others are more questionable. Most of these provisions also can be found in one or more of the other health care reform bills now pending in Congress.

They Chafee bill also contains another set of provisions that are its most significant features. They clearly distinguish the bill from its rivals and are what make it the bold step toward fundamental reform. These are the provisions that deal with the tax treatment of health care. S. 1936 would change federal health

care tax law to help economically marginal workers and their families buy needed medical care and health insurance. The Chafee bill does this by increasing the net number of federal health related tax breaks from four to ten. The bill creates two new tax credits and one new tax deduction for individuals while eliminating an existing tax credit. And the bill creates four new tax credits for businesses and expands the present tax deduction for the self-employed.

Specifically, the bill would make the following changes in the tax code:

1) A Refundable Tax Credit.

The bill would eliminate the current health care Earned Income Tax Credit and replace it with a refundable tax credit for low-income individuals and families. Generally a credit is used to reduce the amount of taxes that must be paid. When a credit is made refundable it means that if the credit exceeds the family's tax liability, the IRS pays the family the difference. Taxpayers will be entitled to the new Chafee credit when they buy health insurance or medical services. The credit would cover 100 percent of these costs up to a maximum of $600 for an individual or $1,200 for a family. The maximum amount of the allowable credit would be reduced by 10 percent of the amount of adjusted gross income in excess of $10,000 for single taxpayers and $20,000 for families. Thus, individuals with gross incomes above $16,000 and families with gross incomes above $32,000 would not be eligible for the credit.

2) Preventive Services Tax Credit.

All taxpayers and their dependents would be eligible for a new, annual tax credit applied to the cost of purchasing specified preventive health services, provided that those services are not already covered by the taxpayer's insurance. The maximum amount of the tax credit would be $250 per individual for taxpayers whose total taxable income is in the 15 percent income tax bracket, and $200 per individual for taxpayers in higher brackets. Doctors and hospitals and other qualified health care providers could claim this tax credit when they give the specified services at no charge to certain low-income individuals. What services would be eligible for this tax credit would be determined by the Secretary of the Treasury and the Secretary of Health and Human Services. At a minimum such services would include: screening tests for breast, colon, rectal, prostate, uterine and ovarian cancer; childhood immunizations; and well-child care.

3) Two Tax Deductions.

The current medical expense tax deduction for individuals who itemize their tax returns would be split into two separate deductions. Taxpayers would be able to deduct all the money that they spend directly on health insurance; no longer would they need to itemize, as they now must, their deductions on their tax returns to claim this deduction. But taxpayers still would be able to deduct only that portion of their out-of-pocket payments for medical services that exceeds 7.5 percent of their adjusted gross income and only they can itemize their deductions. These tax deductions would be reduced by an amount equal to the amount that a taxpayer claimed under the new refundable tax credit.

4) A Small Employer Basic Health Insurance Credit.

Small businesses (defined as firms with between two and 100 employees) would be eligible for a new Small Employer Basic Health Insurance Credit for the first five years in which they offer health insurance to their employees. This new tax credit would be equal to 25 percent of the employer's cost of the health plan for the first year, 20 percent for the second year, 15 percent for the third year, 10 percent for the fourth year, 5 percent for the fifth year, and zero for subsequent years.

5) Managed Care Credit.

Small businesses that begin offering a managed care plan, such as a Health Maintenance Organization (HMO), to their employees would be eligible for an additional Managed Care Credit. In a managed health plan, the patient can select physicians and hospitals only from those specified by the plan. Typically physicians and hospitals participating in a managed care plan must agree to accept the plan's reimbursement schedule and any other restrictions or terms established by the plan. The patient, or his or her employer, is charged a monthly fee for the plan, rather than being sent bills by the health care providers that then must be submitted to the insurer. The new credit would be structured the same way as the Small Employer Basic Health Insurance Credit.

6) A Dependent Care Credit.

Small businesses that begin offering health insurance coverage for their employees' dependents would be eligible for an additional Dependent Care Credit. This too would be structured the same way as the Small Employer Basic Health Insurance Credit.

7) A Small Employer Purchasing Group Health Insurance Credit.

A credit would be available to small businesses that belong to a federally qualified small employer purchasing group that buys health insurance for the employees of all companies that are members of the group. Some of these purchasing groups already exist, and the legislation creates incentives for new groups. Such businesses would be eligible for a credit, in addition to the other credits, equal to 20 percent of the cost of its health plan.

8) The Self-Employed Tax Deduction.

The current tax deduction for health insurance purchased by self-employed individuals would be expanded from 25 percent to 100 percent and made permanent. Another measure sponsored in the Senate (S. 1872) by Lloyd Bentsen, the Texas Democrat, also includes a provision to expand the self-employed health care tax deduction; this bill, however, would make no other changes in health care tax policy.

FLAWS IN THE TAX PROPOSALS IN S. 1936

It is clear from their proposals that the sponsors of S. 1936 recognize that many of the inequities in America's health care system derive from the distortions created by current tax policy. The Chafee bill's sponsors thus are a large step ahead of their colleagues in the Senate Majority Leadership who believe that the best way to solve America's health care financing problems is through a "play or pay" scheme of employer mandates. Such an approach, as contained in S. 1227, sponsored by Senate Majority Leader George Mitchell, the Maine Democrat, actually would expand the current system of employer-provided health benefits while adding a parallel, tax-financed public system for those families not covered at the place of work.

Thus the Mitchell plan would continue the perverse incentives that plague the current system, driving up health care costs for employers, employees, and their families. This proposal is called play or pay because it would require employers to make a choice: either "play" by buying their workers private health insurance coverage or pay higher payroll taxes to fund public coverage of uninsured workers.

From a tax standpoint, this play or pay system would be even more regressive than the existing one. It would try to solve America's health care problems by taxing low-income workers. This is because uninsured workers tend to hold low-wage jobs. The inevitable hidden cost of any government-mandated expansion of employment-based health insurance, or alternative payroll taxes, would be borne exclusively by those workers in the form of reduced cash incomes or lost jobs.[3]

The sponsors of S. 1936 instead recognize that the solution to the health insurance problems of lower-paid workers and their families lies not in more taxes and mandates on employers and workers, but in more direct tax relief for those who find it hardest to pay for health benefits. Hence Chafee and his fellow sponsors attempt to target new health care tax relief to those most in need.

Missing a Chance. While the Chafee legislation is thus on the right track, it embraces a complicated solution over a simple one. In so doing, this bill misses the chance to remedy some of the major flaws in health-related tax policy. These flaws flow from the policy of basing health benefits on the place of work.

The apparent rationale for the many new tax breaks offered in the Chafee bill is a determination to retain the existing system of employer-sponsored health insurance. It is perhaps understandable for lawmakers to try to build on the supposed strengths of the existing system. Chief among these strengths is that over 80 percent of working Americans and their dependents are now covered by employer-sponsored health insurance and thus are accustomed to the system. This

3 See Stuart M. Butler, "Why 'Play or Pay' National Health Care is Doomed to Fail," *Heritage Lecture* No. 329, July 24, 1991.

apparently is the same premise upon which the congressional advocates of "play or pay" base their reform proposals.

Yet company-centered health benefits are, as explained earlier, not a strength but a weakness, and largely an artificial system spawned by the tax exclusion for such benefits. As with "play or pay" bills, Chafee's S. 1936 does not alter the existing tax exclusion, the huge tax break that favors only one type of health insurance—the insurance provided by companies—while giving no tax help for health insurance policies offered by labor unions, or other non-employment groups.

Need for Options. There is no rational or intrinsic reason, philosophic or economic, why workers and their families in effect should be forced to buy their medical care and health insurance exclusively through their employers. To be sure, in some instances there might be economic advantages to doing so voluntarily. But for markets to work properly and efficiently—and hence to the benefit of consumers—consumers must be able to choose from a wide range of options and have the incentive to evaluate their choices in terms of cost and benefit.

From the standpoint of the consumer of health care services, the current system and a play or pay system differ little in practice from a national health insurance system. In each the consumer is the passive recipient of decisions made for him by a third party: either the government or the employer takes the worker's money and then decides, in conjunction with the providers, how it will be spent. The only difference is that in a national health system economic inefficiencies are expressed in the form of explicit rationing or waiting lists for medical care, while in America's system they are expressed in the form of escalating costs. Efficiency—meaning good value for hard-earned money—will only be brought to either system by returning primary control to consumers.

The Chafee bill edges toward empowering consumers to control the money they wish to devote to health purchases by giving some tax relief to direct purchases by consumers of health insurance and medical services. Yet the Chafee bill still would retain some of the worst features of the existing tax treatment of employer-provided health plans. This both reduces the bill's likely impact in effecting a change in the structure of the health care market and leaves the sponsors without the means to pay for their new credits.

HOW TO IMPROVE S. 1936

Returning to consumers control of their health care dollars means limiting and eventually eliminating the tax exclusion for employer-sponsored health insurance. This would encourage consumers to act more efficiently and would end the problems faced by workers when their access to health care and insurance is determined by where they work. Of course, eliminating the tax exclusion would mean the federal government would receive $60 billion a year in new revenues. This should be used to fund a new, more rational system of health care tax relief which provides the greatest benefits to individuals and families with the greatest need, exactly what the authors of S.1936 want to achieve.

The Chafee bill, therefore, could be improved vastly if it would:

1) Establish direct consumer control.

Employers should be required to give workers direct control over the money now spent on their health care and let them decide how best to spend it. To do this, employers with health benefit plans for their employees would increase their employees' cash wages by the value of the health care benefits. A worker then would have several options. The worker could choose to remain with the company-sponsored plan or the worker could seek another plan that offered better value for the money. If the new plan cost less, the worker could pocket those savings. If the worker wanted a plan more generous than that offered by the employer, the worker would pay the additional premium.

2) Grant tax relief directly to families.

Americans should still receive health care tax relief. But instead of restricting consumer choice by providing virtually all the tax relief exclusively for company-sponsored health benefits, taxpayers should be given the same tax relief no matter how or through whom they buy their medical care and health insurance. This means that all Americans should be allowed to claim a new health care tax credit for money spent on health insurance and on out-of-pocket medical care, regardless of how it was purchased.

Consumers could then make key decisions about buying medical care and health insurance without their decisions being influenced or distorted by tax policies which favor one purchasing option over others, as is now the case. Under the new tax credit system, a family would receive health care tax relief directly, and the credit would be applied to all of the family's health expenses. Thus, the family would not be rewarded or penalized by the tax system when it made choices about: from which providers to purchase care; which insurer to purchase coverage from; which services and benefits should be in the plan; and whether to buy health insurance individually or through an employer group or through a non-employer group such as a union, farm bureau, church, local association, or fraternal or professional society.

The Chafee bill would correct some of the existing biases in the tax code which favor certain health care purchasing options over others. It would do this by granting a refundable credit to low income workers, and by liberalizing the deduction for direct health insurance purchases. But the bill would be significantly improved by eliminating those biases entirely.

3) Target tax assistance to those who need it most.

While health care tax breaks should be uniform with respect to the different methods of purchasing medical care and health insurance, they should vary according to the financial and health status of different families. Individuals and families with low incomes or with high medical expenses need more help paying for medical care and health insurance. They thus should receive proportionately more tax relief. The Chafee bill in part recognizes this, and targets most of its tax credits and deductions to families and individuals below certain income levels.

Disparities Remain. The bill, however, does not completely eliminate disparities in the tax treatment of health expenses caused by factors unrelated to health care. Take the example of three taxpayers with identical incomes and identical health expenses, one self-employed, one employed by a company offering comprehensive health benefits, and one employed by a company that requires workers to pay half of their health insurance premiums out of pocket. Under the Chafee bill as currently drafted, each taxpayer still would receive different amounts of health care tax relief, though the disparities would not be as wide as they are under current law.

A better and simpler solution would be to base the size of a new health care tax credit on the income and health expenses of each family, giving more tax relief to those with lower incomes or higher health care costs and make the credit refundable. By varying the percentage rate of the credit according to health expenses relative to income, those individuals or families with lower incomes and/or higher health expenses would receive proportionately more tax relief. Making the credit refundable would mean that very low income workers—who pay little or nothing in income taxes, but substantial payroll taxes—also would receive this tax relief.

A common objection to the use of this kind of tax credit is that families would have to wait until the end of the year to get relief. But this need not be the case. Employers could be required to blend the credit into the existing tax withholding system. A worker does not pay his or her taxes in one lump sum at the end of the year. Instead, the employer is required to withhold those taxes on a pro-rated basis from each of the worker's paychecks. So, too, the amount of the credit would not be paid back to the worker at the end of the year. Instead, the worker would receive the value of the credit on a pro-rated basis in each paycheck during the course of the year. The taxes taken out of each paycheck would simply be reduced to reflect the credit.

To ensure that regular payments are made to each worker's chosen health plan, moreover, employers also could be required to make a regular payroll deduction at the direction of the employee, and send a check to the health plan. Employers currently perform such a service for many 401(k) pension plans, and the federal government in effect does the same for health plans chosen by federal workers.

4) Keep tax relief budget neutral.

The new tax credits in the Chafee bill, or a more general tax credit for all Americans, could be funded by setting a cap on the current tax exclusion for employer-sponsored health benefits, or by gradually eliminating the tax exclusion together with the three other existing health care tax breaks in current law. Thus, new revenues would come into the federal Treasury to fund the new tax credits.

A cap on the exclusion would make the tax credits envisioned in S.1936 "budget neutral" for the federal government; this means that the federal government would receive no more or no less revenue than it now does. This is critical if S. 1936 is to comply with existing budget rules requiring budget neutrality in federal programs. For the same reasons, it is also an essential component of a more preferable, single health care tax credit system.

Rational and Equitable. Under any such "swap" of tax credits for the tax exclusion, Americans in the aggregate would receive roughly the same total amount of health care tax relief they do now. The difference would be that the single tax credit system is a more rational and equitable system of tax relief; it targets the greatest amount of tax relief to families that need it the most. By giving tax relief to workers and their families directly, instead of indirectly through company-based plans, those workers and families will have a much wider choice of health care packages and will be freed from the fear of losing coverage if they change or lose their jobs.

Under this fairer and more rational system of health care tax relief, Americans who buy better value in medical care and health insurance would directly pocket the savings. It would not be returned to the coffers of the company they work for, as it is under the employer-based insurance system. Providers and insurers who offer better value for services would be rewarded with more business.

Current government health programs, such as Medicaid and Medicare for the poor and elderly, would be retained with some modifications. But as the great majority of Americans become more effective health care consumers, costs would be brought under control throughout the system. Further, giving tax help to workers employed by smaller firms without health care plans would induce many Americans now on welfare to rejoin the work force, since leaving welfare no longer would mean losing thousands of dollars of health coverage through the Medicaid program.

CONCLUSION

The chief virtue of Senator Chafee's bill is that it recognizes that the underlying causes of America's health care financing crisis. The Senator and his co-sponsors know that rising costs can be blamed on the distorting effects of federal health care tax policy. The legislation is an important attempt to address those basic flaws, and offers a good starting point for real health care reform.

While other provisions in the bill deal with insurance and other issues, the tax provisions are central. Reforming the tax treatment of health expenses is the essential first step to controlling costs and improving quality in America's health system. The only trouble is, while the Chafee bill goes in the right direction, it is unnecessarily complicated, proposing an elaborate patchwork of new health care tax breaks. It also does not eliminate the perverse incentives caused specifically by the current tax exclusion for company-sponsored health plans.

There is a much simpler and more effective solution. This would be to create a single, refundable health care tax credit for all medical care and health insurance. The generosity of the credit would vary according to the ratio of an individual's or family's total health expenses to total personal income. The higher the impact of health care cost on personal income, the larger the credit. This single credit would replace existing tax breaks, and could be funded by eliminating those tax breaks, particularly the tax exclusion for employer-sponsored insurance.

Aside from simplicity, such a single credit offers other advantages. It would also target assistance to those in greatest need, particularly those unable to obtain traditional employment-based health insurance. It would eliminate the existing disparities between the tax treatment of money spent directly on medical care and money spent on health insurance. It would treat both the same.

Expanding Consumer Choice. It would dramatically expand consumer choice by removing the heavy tax penalty on purchasing health insurance and medical care other than through an employer-sponsored plan. And by giving consumers direct control over the funds used to purchase health care, it would force health insurers and medical providers to respond to consumer demands by offering better quality goods and services at lower prices.

Most important, the result of such a consumer-choice health plan would be what all Americans want: an affordable, equitable, and efficient health care system in which access to health care is no longer dependent on an employer's willingness or ability to provide health benefits.

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