

**Comments for the Record**  
**House Committee on Ways and Means**  
**Subcommittee on Health**  
**Hearing on Medicare Premium Support Proposals**

Friday, April 27, 2012, 9:00 AM

by Michael G. Bindner

The Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic.

The whole purpose of social insurance is to prevent the imposition of unearned costs and payment of unearned benefits by not only the beneficiaries, but also their families. Cuts which cause patients to pick up the slack favor richer patients, richer children and grand children, patients with larger families and families whose parents and grandparents are already deceased, given that the alternative is higher taxes on each working member. Such cuts would be an undue burden on poorer retirees without savings, poor families, small families with fewer children or with surviving parents, grandparents and (to add insult to injury) in-laws.

The key issue for the future of health care finance is the impact of pre-existing condition reforms on the market for health insurance. Mandates under the Affordable Care Act (ACA) may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether for constitutional reasons.

If people start dropping insurance until they get sick – which is rational given the weakness of mandates – then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.

In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support also will not work if the ACA is repealed, since without the ACA, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.

The alternative of single-payer catastrophic insurance with health savings accounts would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

Bruce Bartlett wrote in the New York Times Economix Blog on May 17, 2011 on the nature of the Medicare financial problem and how to fix it. The information he imparted is invaluable, however I disagree with his solution, which is to stop doing the Doc Fix. He relates that the ACA expansion of funding brought the Hospital Insurance Trust Fund (Part A) into balance, with parts B (doctor visits) and D (Drug coverage) responsible for most of the unsustainable cost growth, as patient premiums are set to 25% of program costs and with drug coverage premiums covering even less.

The Center believes that stopping doctor bills from going up on the demand side will not work. We know that because it did not work for Medicaid - since restricting payments have stopped most doctors from taking Medicaid). This finding has a great deal of impact on what is possible in preventing the doctor fix.

The problem with Medicare Part B is that increases cannot keep up with costs, like they do in the private market, because doing so violates the commitment to not cut Social Security benefit checks. The cost of living adjustment must be high enough to cover the premium increase each year - although for many that is all it does. Further cuts bring up the specter of seniors eating cat food to make ends meet, hence the reason that the Fiscal Commission was called the Cat Food Commission by progressives.

Premium support and not patching doctor fees are attempts to make doctors restrict their costs - both to seniors and overall. Prices naturally rise more quickly than inflation because these services are subsidized, so any co-pay must be increased to slow demand from users in exactly the same way the market would without subsidies or insurance. The desire to make doctors pay more is a recognition that the main impact of both insurance and subsidies (and subsidies for insurance) is higher income for doctors and a larger medical care sector than would otherwise occur in a free market.

Our hybrid system is the most expensive option - either going to much less comprehensive insurance for everyone or an entirely governmental system would be cheaper, but is politically untenable (at least until private insurance collapses or is eventually supplanted by an ever expanding public option).

Going after doctors still won't work, however, as the Medicaid experience clearly shows. Premium support is a way to have insurance companies go after doctors instead, but that will likely yield the same result.

Making patients more conscious of their care might do the trick, both with more realistic premiums for Part B and Part D, with both rising to absorb half the cost - although premiums could be lowered by increasing co-pays and providing seniors with Flexible Spending and/or health savings accounts. The problem is that this is untenable when dealing with a population with largely fixed incomes. That problem, however, is not unsolvable.

The obvious solution, which no one has yet suggested, is to change how COLAs are calculated, moving from the wage index to an index based on what seniors actually buy - especially health care. If premiums were increased quickly, COLA changes would have to be as rapid.

Such a proposal would hasten the date that the Old Age and Survivors Insurance fund needs rescue. It also impacts lower income seniors to a greater extent than higher income seniors, since they have less left over after any mandatory co-pay. Either bend points would have to be reset or the entire complicated system of bend points would have to be replaced a new method of crediting contributions, where employer contributions are credited equally rather than as a match to the employee contribution - thus moving redistribution from the benefits side to the revenue side.

An average employer contribution would provide even more incentive for increasing the amount of income subject to benefits, at least for the employer contribution. Of course, if you do the latter, we might as well simply use a Net Business Receipts Tax or a VAT to replace the employer contribution (which captures all income with the latter burdening imports as well)

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding).

We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so we will confine our remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns. The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

The NBRT would replace disability insurance, hospital insurance, the employer contribution to old age and survivors insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet  
Michael Bindner  
Center for Fiscal Equity  
4 Canterbury Square, Suite 302  
Alexandria, Virginia 22304  
571-334-8771  
fiscalequity@verizon.net

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