

Comments for the Record
House Committee on Ways and Means
Subcommittee on Health
Hearing: Expiring Medicare Provider Payment Policies

September 21, 2011, 2:00 PM

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. This topic is key to the question of the affordability of health care entitlements. It is useful to compare the impact of how provider limits have been dealt with between the Medicare and Medicaid programs.

Medicare provider cuts under current law have been suspended for over a decade, the consequence of which is adequate care. By way of comparison, Medicaid provider cuts have been strictly enforced, which has caused most providers to no longer see Medicaid patients, driving them to hospital emergency rooms and free clinics with long waiting periods to get care.

The Affordable Care Act works toward increasing funds for Medicaid providers, which is necessary to get people out of emergency rooms. The same act, however, counted on assuming that Medicare provider cuts would be implemented – a heroic assumption – in order to pass according to budget rules. Now that the Act is passed, however, the fiction that current law will be maintained can be dispensed with.

Parity between Medicare and Medicaid is desirable, although without mandatory sick leave, it will not keep poor people from having to use emergency room care, although it will benefit nursing home patients who will be able to see a doctor without hospitalization.

Separating Medicaid into a program for retirees and a program for the non-retired working and non-working poor will allow the retiree program to be fully federalized and managed with Medicare, rather than the separate management that occurs now under CMMS, which is part of the problem. That simple step will add clarity to this issue.

There are many ways of achieving parity, however great care must be used so that these don't constitute a race to the bottom. Cost shifting should not be used as a substitute for cost saving, especially if such shifting violates the tenants of social insurance.

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.

Recent history shows what happens when benefit levels are cut too drastically. Prior to the passage of Medicare Part D, provider cuts did take place in Medicare Advantage (as they have recently). Utilization went down until the act made providers whole and went a bit too far the other way by adding bonuses (which were reversed in the Affordable Care Act). There is a middle ground and the Subcommittee's job is to find it.

Resorting to premium support, along with the repeal of the ACA, have been suggested to save costs. Without the ACA pre-existing condition reforms, mandates and insurance exchanges, however, premium support will not work because people will have no assurance of affordable coverage. This, of course, assumes that private insurance survives the imposition of pre-existing condition reforms. If it does not, the question of both premium support and the adequacy of provider payments is moot, since if private insurance fails the only alternatives are single-payer insurance and a pre-emptive repeal of mandates and protections in favor of a subsidized public option. The funding of either single-payer or a public option subsidy will dwarf the requirement to fund adequate provider payments in Medicare and Medicaid.

Resorting to 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.

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 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.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a “balanced budget” rate. It could be set lower if the spending categories funded receive a supplement from income taxes.

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

Subcommittee on Health**Hearing: Expiring Medicare Provider Payment Policies****September 21, 2011, 2:00 PM**

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.