

Comments for the Record
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Hearing on MPAC's March Report to Congress
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The Center for Fiscal Equity

Chairman Brady and Ranking Member McDermott, thank you for the opportunity to submit my comments on this topic. As there has been turn-over in the membership of the committee, we will largely repeat our comments from last year, which provide real alternatives to current policy, as well as current problems that no one is talking about relating to the implementation of the Affordable Care Act. We are always available to brief members and staff individually on our comments or respond to any questions.

It is always important to note that 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. We do not have to wait until implementation to examine this question. Now that the Supreme Court has spoken, the stock market will examine it for us. There may well be a demand for reform before the election if the prospects for private insurance are found wanting. Conversely, if stock prices are maintained, it is the market expecting mandates to be adequate.

Assuming mandates are seen as inadequate, the questions of both premium support and the adequacy of provider payments are 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.

The question of Accountable Care Organizations and cost sharing with payments is also relevant. The Senate Finance Committee addressed this question last year. Hearing witnesses focused on Accountable Care Organizations and other possible solutions to bend the cost curve. This emphasis is all well and good of most beneficiaries of Medicare, Medicaid and other forms of directly and indirectly subsidized insurance in most years. Focusing on results is a worthy goal for both patient well being and cost control, provided the patient can be treated. Medicare, however, devotes significant resources to the expensive care found in the last year of life, which may involve multiple hospitalizations, full time nursing services through Medicaid or a period of intensive care which ultimately proves unsuccessful. In all of these circumstances, particularly the last, unless we are willing to either have doctors deny care or force survivors to pay bills that the government refuses to pay, some form of fee for service is necessary.

In April of 1998, our Principal's father, Jim Bindner, had a heart attack, due in part to either an undetected acute episode of diverticulitis (which was not detected until autopsy) and in part to a lack of oxygen resulting from successful radiation treatment for metastatic lung cancer. Had this attack occurred today, there is a chance that advances in emergency medicine, including cooling of the patient, might have resulted in a successful outcome. This strategy, however, did not exist in 1998 and is still not widely practiced. As a result, resuscitation was incomplete and Mr. Bindner was left in a coma in intensive care for almost a week before he passed.

The relevant question is, what would a results based medicine scenario pay for in situations such as this? Would the government have forced Mercy Medical Center to simply eat the costs? If so, would there have been pressure from the hospital to end care sooner? Would the alternative have been a copayment for these services for the family?

Worse yet, would someone have forced the choice on Mrs. Bindner to either agree to payment or discontinue life support earlier to save cost? These are the questions that such modalities as results based payment bring forward loud and clear and they will hit every family with children of a certain age. This is not the specter of the death panel. It is something much worse – a demand to agree to pay or make a tragic decision at the most difficult time in anyone’s life.

Tragically, Mrs. Bindner followed her husband in death last year one month after our last comments. We were not faced with a decision to disconnect before we were ready, although we did withdraw support and allow her to die in peace once it was confirmed there was no brain function. If it had been the choice of some insurance bureaucrat rather than our choice, a tragic situation would have been made worse.

While some families could, of course, afford to pay for greater end of life services, the prospect that money might buy longer life, or a greater chance for miraculous recovery to occur, would turn such care from what is now a right to a commodity. The Center finds this unacceptable.

In fee for service medicine, this choice is simply not required. Certainly the richest society on the planet can afford to allow women facing imminent widowhood to avoid such heart breaking choices if possible. Recent reforms have essentially turned the Medicare Part A Payroll Tax into a virtual consumption tax already by taxing non-wage income above \$250,000 a year. It would be as easy to shift from a payroll tax to a value added or VAT-like net business receipts tax (which allows for offsets for employer provided care or insurance) and would likely raise essentially the same amount of money, as most non-wage income actually goes to individuals now liable for increased taxes. If a VAT system is used, tax rates can be made lower because overseas labor will essentially be taxed, leaving more income for American workers while raising adequate revenue.

Premium support systems would not have any impact at all on end of life care decisions, except to the extent that they lead to cost cutting and the kind of choices mentioned above that we can all hopefully agree are abhorrent. Ultimately, this negates much of the cost savings that could come from premium support, so this idea should be dropped.

A single-payer catastrophic plan would guarantee payment by the widow of any difference between the catastrophic deductible and the accumulated health savings account. This, again, is the last thing any widow should have to face, even if the survivors have adequate insurance.

Replacing payroll taxes with Value Added Tax (VAT) funding will have no impact on whether fee for service medicine at the end of life continues, except for the fact that more adequate funding makes the need to save costs less urgent.

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.

One form of increased funding could very well be higher Part B and Part D premiums. This has been suggested by both the Fiscal Commission and the Bipartisan Policy Center. In order to accomplish this, however, a higher base premium in Social Security would be necessary. Our proposal is that to do this, the employee income cap on contributions should actually be lowered to decrease the entitlement for richer retirees while the employer income cap is eliminated, the employer and employee payroll taxes are decoupled and the employer contribution credited equally to each employee at some average which takes in all income. If a payroll tax is abandoned in favor of some kind of consumption tax, all income, both wage and non-wage, would be taxed and the tax rate may actually be lowered.

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), regardless of whether Part B and D premiums are adjusted. If the same consumption tax pays both retirement income and government health plans, the impact on the taxpayer is exactly nil in the long term.

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 not 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.

Adoption of the NBRT does offer some interesting questions to the extent that offsets are allowed. This shifts the ethical locus from the government to employers, although the government would, of course, require superior coverage to use any offsets. Still, the decision-makers on the ground would not be someone at CMMS, but someone in the corporate benefits office. While the practice of buying life insurance for employees with the firm as beneficiary certainly mitigates the cost, it might also appear ethically problematic if the payout encourages the disconnection of support earlier than the family finds comfortable.

The form of the employer's company providing care in lieu of tax payment matters in this case. A firm with outside shareholders, even if it is a model of compassion, will always be looked upon as potentially untrustworthy in allocating end of life care, especially given their greater incentive to do so to minimize costs which would otherwise go to profit. Employee-owned firms, however, might be regarded as more trustworthy making these decisions, since employees would be responsible to each other rather than to outside owners for cost minimization. We believe such firms are less likely to force hard end of life choices on widows, at least for financial considerations.

As we have stated previously, shifting the Old Age, Survivors and Disability Insurance Employer Payroll Tax to a VAT-like Net Business Receipts Tax can facilitate the accumulation of employee-owned shares, especially if a faster transition which includes current retirees, who must be made whole (with some of these transition funds being provided by the U.S. Treasury from the OASI Trust Fund), will result in a lower NBRT levy immediately and in the future. Converting retained equity to employee-ownership may give some firms the opportunity to transition far quicker than any other plan envisions.

These proposals can solve the problem of rural health care as well. Provided employers don't relocate (and more employee-ownership makes this less likely), the infrastructure which provided health care to workers would continue to exist for retirees. Employee-owned firms might also take on sponsoring the training of doctors with the condition that they locate in rural areas where they operate and have retirees.

In a single payer or public option system, incentives can be paid to doctors who move to rural areas. Of course, if we simply expanded the Uniformed Public Health Service to a British style National Health System, there is no issue of where doctors want to practice, they would simply be assigned to the areas where they were needed.

Currently, much in the way of rural health care comes from members of the Catholic Health Association. In our previous example, end of life care was provided in such a hospital in a rural area. As long as these hospitals continue to exist, there will be some base of health care in rural areas – provided we as a nation do not take advantage of their charity by cutting provider rates with the expectation that they will always be a low cost provider or raise money to pick up the slack. The Sisters who own and run these hospitals have a retirement income crisis of their own, so deliberately underpaying them is not a good long term strategy for assuring rural health care exists in the long term.

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.

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