

**Comments for the Record**  
**U.S. House of Representatives**  
**Committee on Ways and Means**  
**Subcommittee on Health**  
**Hearing on Examining Traditional Medicare's Benefit Design**

Tuesday, February 26, 2013, 10:30 AM

By Michael G. Bindner

Center for Fiscal Equity

Chairman Brady Ranking Member McDermott, thank you for the opportunity to submit these comments for the record to the House Ways and Means Committee. We remain available to brief members and staff on our proposals for retirement and health care reform.

It is always important to note when discussing reform options 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, had been suggested to save costs. It is our hope that the election results took this off the table, however we will reprise our analysis of this option if and when it comes up.

One option is resorting to single-payer catastrophic insurance with health savings accounts. It 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 bigger question is whether 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 Act is fully implemented if the prospects for private insurance are found wanting. Conversely, if stock prices are maintained, it is the market expecting mandates to be adequate. This question is by far more important than the design of the traditional system.

If 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 consumer 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.

.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.

Recent reforms have essentially turned the Medicare Part A Payroll Tax into a virtual consumption tax 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.

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 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.

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**

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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.