

**Comments for the Record**  
**House Committee on Ways and Means**  
**Subcommittee on Oversight**  
**Hearing on the Impact of Limitations on the Use of Tax-Advantaged Accounts for**  
**the Purchase of Over-the-Counter Medication**

April 25, 2012, 2:30 PM

by Michael G. Bindner

The Center for Fiscal Equity

Chairman Boustany and Ranking Member Lewis, thank you for the opportunity to submit my comments on this topic. We largely agree that limiting tax advantaged plans is not a good move for cost cutting, provided that use of these accounts do not adversely affect access to care. Sadly, there were problems with these vehicles even before passage of the *Affordable Care and Patient Protection Act*. While the Center is in favor of undoing these limits as part of reform, it is unwise to simply undo the act to return to a bad status quo.

The real danger to the success of the Act is the possibility of the failure of private insurance generally. The key issue for the future of health care consolidation 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. One 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. Another alternative is to pass single-payer catastrophic insurance featuring both Health Savings and Flexible Spending Accounts – however these should be used in concert, with one card (in former days called a Health Security Card) accessing both the catastrophic plan, the HSA and the FSA.

Flexible spending accounts, especially self financed ones, can be used to end the debate over services that some insurers or religious employers do not believe in funding, from acupuncture and cranio-sacral therapy to contraception and abortion, as well as over the counter medications and even medical marijuana in states where it is legal (which is a growing number). Of course, these accounts could also be limited to the gap between the catastrophic deductible, the available HSA balance and needed costs, although once you reopen the door to OTC medications, it will be hard to stop others from piling on.

Ideally, the system should fund both a public option for people who cannot get care because of cost or pre-existing conditions, allowing others to keep their employer provided care and covering the remainder with a low cost single-payer catastrophic plan provided by the government, with employers funding the HSA and employees funding the FSA. Of course, this level of convenience takes some of the impetus away from cost savings, however as health care is not a normal good that responds to market pressures, this is probably a good thing.

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. For example, 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.

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 I will confine my 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).

This option would be particularly attractive to small businesses. It would essentially broaden the tax credit in the ACA. The current tax regime does not serve to encourage use of the Small Business Tax Credit, which in any case should be merged with the health insurance exclusion as part of an NBRT collected on all businesses, regardless of filing status.

The key to utilization is to increase the tax rate enough to encourage use and requiring such tax benefits for health care and our proposed expanded and refundable Child Tax Credit before any other exclusion are taken, including any zero rating of exports (which is why zero rating is not recommended for this tax).

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, although we expect that only larger businesses will go to those lengths. 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.

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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