

**Comments for the Record**  
**U.S. House of Representatives**  
**Committee on Ways and Means**  
**Subcommittee on Health**  
**Hearing on Physician Organization Efforts to Promote High Quality Care and**  
**Implications for Medicare Physician Payment Reform**

July 24, 2012, 10:00 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. This hearing allows us to highlight comments made last month on the implications of physician payment reform.

As I stated in our last comments:

In April of 1998, (my) 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.

Since these comments were made, my mother was the victim of a gas leak when her foundation shifted. Neighbors found her, roused her and moved her to safety and all was looking well until she collapsed with no vital signs once paramedics arrived. This began two days of intensive care after she was revived in the ambulance, but never regained consciousness. She died two days later when we removed life support because no measurable brain function could be detected, even after cooling was tried.

The relevant question remains as it did in my father's case, 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 my siblings and I 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.

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 for Fiscal Equity and my family find 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.

Thank you for the opportunity to address the committee and share what many of my generation regard as very real concerns, both as our parents age and we approach that stage of life where such decisions may apply to us. I am, 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.