

Policy Analysis

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Routing

Medicaid's Unseen Costs

by Michael F. Cannon

Executive Summary

Medicaid occupies a special place among government programs for the poor. Public support for Medicaid is broader and deeper than for other safety net programs because the consequences of inadequate medical care can be much more immediate and severe than those of a lack of money or even food.

That may be one reason voters have heretofore accepted the rapidly growing tax burden Medicaid imposes. Medicaid is now larger than Medicare (the federal health program for the elderly and disabled) and is the single largest item in state budgets, even larger than elementary and secondary education.

To curb this growing financial burden, states (led by Tennessee) are dropping hundreds of thousands of eligible individuals from their programs. Congress has resolved to reduce federal Medicaid spending by nearly 1 percent over the coming five years and has created a commission to recommend short-term savings and long-term structural reforms.

Yet Medicaid imposes additional hidden costs. Like all means-tested government programs, Medicaid discourages work and charitable effort among the taxpayers who fund it, while discourag-

ing self-sufficiency and encouraging dependence among beneficiaries. Medicaid also imposes costs that stem from overuse of medical care, increasing costs for private payers, and giving patients poorer-quality care than they could obtain with private coverage.

As it did with federal cash assistance, Congress should: (1) cap federal Medicaid spending, (2) block grant federal funds to the states, and (3) allow states full flexibility to define eligibility and benefits under their Medicaid programs. States should use that flexibility to target Medicaid assistance to the truly needy, reduce dependence, reduce crowd-out of private effort, and promote competitive private markets for medical care and insurance. That means withdrawing assistance from those who are most able to obtain coverage elsewhere and deregulating health care and health insurance markets so they can meet that need.

Providing efficient medical care to the poor without fostering dependence is a delicate balancing act, and many of the costs incurred by getting it wrong don't get a line item in the federal budget. Reforming Medicaid along the lines of the 1996 welfare law would allow the states to strike a better balance for all involved.

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A body of literature supports the view that Medicaid actually exacerbates the problems of poverty and the lack of affordable medical care.

Introduction

There is only one difference between a bad economist and a good one: the bad economist confines himself to the visible effect; the good economist takes into account both the effect that can be seen and those effects that must be foreseen.

Frédéric Bastiat

That Which Is Seen, and That Which Is Not Seen (1850)

Medicaid is the largest means-tested government program in the United States. Enacted in 1965, it provides medical care to tens of millions of low-income Americans. Supporters praise the program for making essential care available to those who otherwise could not afford it. Many argue that millions more Americans find health insurance unaffordable and therefore should be brought under Medicaid's umbrella. However, a body of literature supports the opposite view: that Medicaid actually exacerbates the problems of poverty and the lack of affordable medical care. Current public policy debates lack a robust examination of the unseen costs of Medicaid.

Program Features

Medicaid subsidizes health care for low-income Americans. The federal government and state and territorial governments jointly administer Medicaid—or more precisely, 56 separate Medicaid programs.¹ Although participation is ostensibly voluntary for states, all states participate.

Each state's Medicaid program must provide a federally defined set of benefits to a federally defined population of eligible individuals. States can expand eligibility and benefits beyond the minimum federal requirements. In 1997 the federal government created the State Children's Health Insurance Program, which allows states either to expand their Medicaid programs to include children in families with slightly higher incomes or to enact a parallel

and more flexible program for such children.

Each state receives federal funds in proportion to what it spends. The more a state spends on its Medicaid program, the more it receives from the federal government. The ratio of federal to state contributions, or "match," changes from state to state and is determined according to a state's relative wealth. Relatively high-income states receive a dollar-for-dollar federal match. Some poorer states receive as many as three federal dollars for each dollar they put forward.² On average, 57 percent of Medicaid funding comes through the federal government, and 43 percent comes through states.

For beneficiaries, Medicaid is an entitlement. As long as an individual meets the eligibility criteria, he or she has a legally enforceable right to benefits. Medicaid typically offers services to beneficiaries free of charge.³ The program primarily serves four low-income groups: mothers and their children, the disabled, the elderly, and those needing long-term care. In 2004 Medicaid subsidized health care for more than 50 million Americans. They included some 38 million low-income children and their parents and 12 million elderly and disabled beneficiaries. In addition to benefits provided to those enrolled in the program, Medicaid's disproportionate share hospital (DSH) program provides added federal funding to hospitals that treat a disproportionate share of uninsured patients.

Although the vast majority of Medicaid *beneficiaries* are low-income children and their families, the vast majority of Medicaid *spending* goes for the elderly and disabled, who use far more care than their younger counterparts. In 2002 Medicaid spent \$1,475 per covered child, compared to an average of \$11,468 per disabled beneficiary and \$12,764 per elderly beneficiary. The elderly and disabled account for about 70 percent of Medicaid spending. Medicaid provides supplemental subsidies for approximately six million Medicare beneficiaries, who account for 40 percent of Medicaid spending. Medicaid finances nearly half of all nursing home care in the United States.⁴

Medicaid pays for covered services according to fixed prices that are set administratively. Medicaid payments to providers are typically lower than those made under Medicare, which also uses administrative pricing that is well below payments from private payers. Providers participate in Medicaid on a voluntary basis.

Medicaid Spending

From its inception, Medicaid has imposed a rapidly growing burden on taxpayers. By its fifth year of operation, actual Medicaid spending had reached double the official projections. That was “primarily because analysts greatly underestimated the extent to which States would offer coverage of optional eligibility groups . . . and optional services. Enrollment growth also greatly exceeded original expectations.”⁵

A number of factors drive growth in Medicaid spending. Many of those will be discussed later. A large share of the growth comes from recent expansions of state Medicaid programs. Encouraged by federal State Children’s

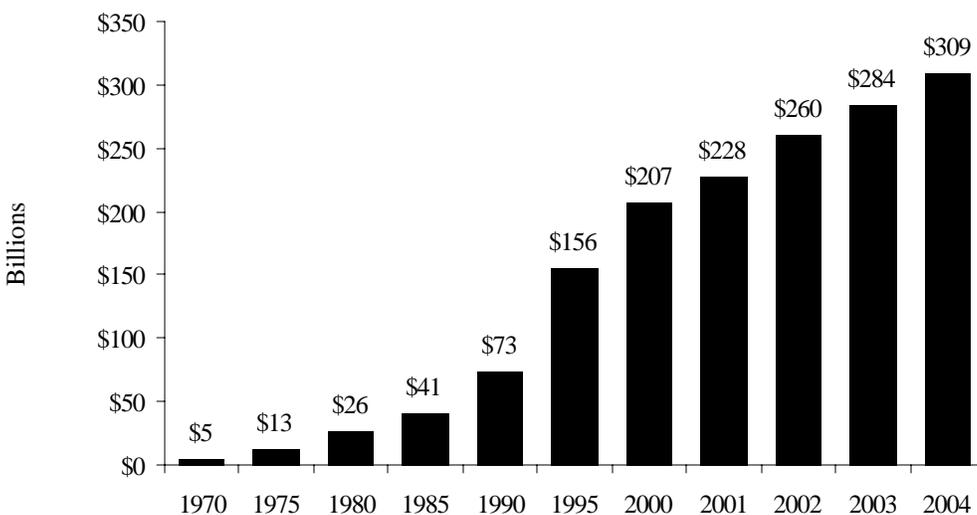
Health Insurance Program funds and overflowing tax coffers, states greatly expanded optional benefits in the 1990s.⁶ Another source of spending growth is the rising cost of medical care. Many observers argue that the rising cost of private health insurance and the resulting growth in the number of Americans without it lead to greater Medicaid enrollment and spending. Finally, as the population ages and longevity increases, more Americans are relying on Medicaid to provide nursing home and other long-term care.

As the economy slowed in 2001, a drop in tax revenues left states unable to meet the commitments they had made. According to the National Association of State Budget Officers: “Twenty-three states experienced Medicaid shortfalls in fiscal 2003 and 18 states anticipated shortfalls in fiscal 2004. The shortfalls as a percentage of the total Medicaid program in fiscal 2003 reached as high as 16.4 percent of program costs. The combined amount of the shortfalls in fiscal 2003 and fiscal 2004 totaled nearly \$7 billion.”⁷

In response, all 50 states have taken steps to contain Medicaid spending, including restricting access to prescription drugs, freezing pay-

By its fifth year of operation, actual Medicaid spending had reached double the official projections.

Figure 1
Total Medicaid Spending, Select Years, 1970–2004



Source: National Association of State Budget Officers, “2003 State Expenditure Report,” October 2004, p. 47.

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ments to providers, reducing eligibility and benefits, and increasing patient copayments.⁸ All states have reduced provider payments and access to prescription drugs. Two-thirds of states have restricted eligibility or benefits. In particular, Tennessee governor Phil Bredesen (D) is attempting to cut 323,000 people from that state's TennCare program.⁹ Mississippi has sought to eliminate eligibility for 65,000 Medicaid beneficiaries.¹⁰ Missouri plans to remove 90,000 beneficiaries from its Medicaid rolls¹¹ and has gone as far as to sunset its Medicaid program in 2008.¹² Half of the states plan to cover their shortfall by increasing taxes.

Such measures are likely to continue. Medicaid spending continues to grow faster than all other state budget items and now accounts for more than 21 percent of state spending.¹³ The National Association of State Budget Officers estimates that total Medicaid spending reached \$309 billion in 2004, surpassing elementary and secondary education as the largest item in state budgets (see Figure 1).¹⁴ That organization reports, "Even after a full economic recovery is underway for state budgets, increases in Medicaid costs will far outstrip the growth in state revenues into the future."¹⁵

In its budget for fiscal year 2006, Congress will grapple with runaway Medicaid costs. Congressional Republicans have pledged to reduce Medicaid spending by \$10 billion, or just less than 1 percent, over the next five years. Congress also created a Medicaid Advisory Commission to make recommendations by September 1, 2005, on how to attain those short-term savings. That commission is further charged with making recommendations "that ensure the long-term sustainability of the program." Those recommendations are due by December 31, 2006.¹⁶

Medicaid's Unseen Costs

Medicaid's most obvious effect is the access to medical care it provides its beneficiaries. However, Medicaid imposes a number of unseen costs associated with anti-

poverty efforts generally. For example, it discourages self-help. Medicaid is a means-tested program; if an individual's income exceeds a certain amount, that person loses eligibility. Thus, poor recipients may fail to climb out of poverty if it would mean losing Medicaid benefits, which average more than \$6,000 per beneficiary. Likewise, individuals who are not poor may allow themselves to fall into poverty to obtain Medicaid subsidies. Finally, the tax burden Medicaid imposes on near-poor individuals—which includes Medicaid's effect on the cost of private medical care and health insurance—may frustrate the efforts of those who want to lift themselves out of poverty. (The taxes required to finance Medicaid may also discourage work on the part of other taxpayers.) Forgone self-help efforts are an important unseen cost of Medicaid.

Just as Medicaid's means-tested subsidies discourage self-help generally, they discourage other efforts to provide medical care to recipients (and potential recipients). This effect is typically referred to as "crowd-out" of other efforts. For instance, eligible individuals may rely on Medicaid to finance their medical care rather than take steps (such as mutual aid or purchasing private health insurance) to cover their own medical expenses. Likewise, in most cases, the availability of matching federal funds encourages states to increase medical assistance to the poor. However, states can use Medicaid revenue to displace effort they would otherwise exert themselves. Individuals who are not poor may reduce charitable efforts to provide medical care to the needy because they believe the problem to be taken care of or because Medicaid's total tax burden makes them less able to donate. In those and other ways, Medicaid crowds out potentially more efficient ways of targeting resources to the identified need.

Many of Medicaid's unseen costs are specific to in-kind programs. These include costs that stem from the overuse of medical care, increasing costs for private payers, and giving Medicaid patients poorer-quality care than they could obtain with private coverage.

Behavioral Responses

Many of Medicaid's unseen costs result from the ways in which individuals and institutions respond to the existence of the program and the benefits it offers.

Recipients

Medicaid's most crushing unseen costs result from its discouraging private efforts to alleviate poverty and to provide medical care for actual and potential beneficiaries. Anyone who meets federal eligibility criteria (regarding age, income, family structure, etc.), or a particular state's broadened criteria, is entitled to Medicaid benefits. This encourages many people to enroll even when they could obtain care and coverage elsewhere.

Individuals sometimes respond to means-tested government programs by failing to take steps they would otherwise take to alleviate their own poverty. Because eligibility depends on one's income and assets, many beneficiaries become or remain eligible by avoiding self-help—such as striving to earn more or save more—that would make them ineligible. The prospect of losing Medicaid benefits can be a significant deterrent for individuals who might otherwise enter the workforce or increase their earnings. University of Kentucky economist Aaron Yelowitz explains the effect Medicaid has on the incentive to work:

Until 1987 the income eligibility limit (the maximum income allowable to receive benefits) for Aid to Families with Dependent Children (AFDC) was effectively the same as the income limit for Medicaid. This meant that at a predefined level of earnings, both AFDC and Medicaid benefits were lost. Losing Medicaid abruptly created a large and negative “notch” in income realized from work, totaling several thousand dollars. Because of this notch problem, a welfare recipient who increased her earnings above the income limit would actually make her family worse off than

before. The notch contributed to keeping families dependent on welfare and discouraged the movement of welfare recipients into the workforce.¹⁷

Yelowitz observed that many beneficiaries would have to *double* their earnings before their additional work effort brought their total income back up to what it had been before they became ineligible for Medicaid.¹⁸

Yelowitz found that this disincentive to work affected the behavior of Medicaid recipients. He found that when income limits for Medicaid eligibility were raised in the late 1980s and early 1990s, enrollment in Aid for Families with Dependent Children fell. He posits that this response came from AFDC recipients who previously could have found work and who no longer would lose their Medicaid benefits if they did so. He estimates that the change in Medicaid eligibility was responsible for a 6.3 percent decline in AFDC caseloads.¹⁹

Since 1996 the link between AFDC (now Temporary Assistance for Needy Families) benefits and Medicaid benefits has been broken, and states have raised Medicaid income limits. Yelowitz observes, “As states have expanded eligibility for Medicaid by increasing the income limit to a higher level . . . the notch has moved.”²⁰ The sharp reduction in overall income that used to accompany increases in earned income has been moderated by gradual reductions in Medicaid benefits as earned income increases. Such measures can lower the marginal “tax” rate that the loss of benefits imposes on additional earnings. However, they cannot eliminate it. Moreover, such benefit “phase-outs” lower that marginal tax rate by applying it to a broader income range. As a result, Medicaid's disincentives to work, earn, and save have moved up the income scale and now affect more low-income individuals.

Another form of self-help that Medicaid discourages is wealth accumulation. There are two reasons this may happen. Eligible individuals may reduce precautionary savings if they know their medical expenses will be paid by government. In addition, the value of an indi-

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vidual's assets is often used to calculate eligibility; thus some people may reduce or avoid asset accumulation to become or remain eligible.

Yelowitz and MIT's Jonathan Gruber found that Medicaid eligibility was associated with reduced asset holdings²¹ among nonelderly households. Rather than accumulate assets, recipients shifted income to consumption. Increased consumption does not jeopardize eligibility, but substituting consumption for asset accumulation (such as purchasing a car for transportation to work) decreases the likelihood of escaping poverty. Yelowitz and Gruber estimate that in 1993 Medicaid reduced asset holdings among eligible households by the equivalent of \$1,600 to \$2,000 in today's dollars.²²

Asset tests for nonelderly Medicaid beneficiaries are increasingly less common. By 2004, only five states required household asset tests when determining children's eligibility, although 28 states still required asset tests for determining parents' eligibility.²³ Where asset tests still exist, they likely create even larger disincentives to accumulate wealth now than in 1993 as a result of subsequent expansions of eligibility and benefits. Large exemptions from asset tests allow significant numbers of well-to-do seniors to rely on Medicaid for nursing home and other long-term care.²⁴

Asset tests present policymakers with a tradeoff between undesirable effects. If asset limits are low, individuals will impoverish themselves, whether in reality or on paper, to become or remain eligible for a subsidy. Thus low asset limits can lead to both increased poverty and increased fraud. On the other hand, raising or eliminating asset limits opens Medicaid to wealthier individuals. Thus the gradual elimination of asset tests results in scarce tax dollars going to less needy beneficiaries. Such expansions in turn increase other types of crowd-out.

The most-researched way that Medicaid leads eligible and potentially eligible individuals to alter their behavior is by encouraging them not to take steps to finance their own medical expenses. Such steps include engaging in private communal assistance or self-

help, such as purchasing private health insurance.

Prior to the enactment of Medicaid, many working-class Americans financed their medical expenses with the help of fraternal organizations, also known as mutual aid societies. According to historian David Beito, by 1920 such organizations "dominated the field of health insurance. They offered two basic varieties of protection: cash payments to compensate for income from working days lost and the care of a doctor. Some societies . . . founded tuberculosis sanitariums, specialist clinics, and hospitals." Beito writes, "A conservative estimate would be that one of three adult males was a member [of such organizations] in 1920, including a large segment of the working class." Moreover, these organizations "achieved a formidable presence among blacks and immigrant groups."²⁵

Beito focuses on the effect that government-provided medical care for the poor had on mutual aid societies' efforts to provide medical care to low-income residents of the Mississippi Delta. "For twenty-five years before 1967," he writes,

"thousands of low-income blacks in the Mississippi Delta obtained affordable hospital care through fraternal societies. Although there were clear deficiencies, the quality was reasonably good, especially given the limited resources. Most importantly, the Taborian Hospital and the Friendship Clinic excelled in providing benefits to patients that were not easily quantifiable, including personal attention, comfortable surroundings, and community pride. Both societies accomplished these feats with little outside help. The Knights and Daughters of Tabor and the United Order of Friendship of America forged extensive networks of mutual aid and self-help for thousands of low-income blacks."²⁶

However, the advent of federal assistance changed the landscape. "In 1966 the federal Office of Economic Opportunity (OEO), the

major front-line agency in the War on Poverty, entered the scene with subsidized health care,” Beito writes. “The next year witnessed the end of fraternal hospitalization in the Delta.” At the time, the leaders of the Knights and Daughters of Tabor wrote: “Since 90% of our membership is composed of people who are classified in the poverty category—they are eligible for free care at the Mound Bayou Community Hospital. Therefore, we are losing their membership in the order. This puts the Order in a declining position in membership and financial income.” Beito continues: “The rapid inflow of federal money dampened the community’s old habits of medical mutual aid and self-help. According to Dr. Louis Bernard of Meharry Medical College, ‘The dollars available from the so-called antipoverty program ruined the International Order of the Knights and Daughters of Tabor.’”²⁷

Beito focused mainly on the effects of federal subsidies that created hospitals, not Medicaid explicitly. However, Medicaid accounts for a notable share of hospitals’ income and was one of the changes that occurred during this period, having been enacted in 1965.²⁸

In addition, Medicaid encourages employers of low-income workers not to offer coverage and encourages low-income workers not to enroll in private coverage. Researchers at the Robert Wood Johnson Foundation surveyed 22 leading studies on whether “free” government coverage crowds out private coverage and concluded that such crowd-out “seems inevitable.” More than half of those studies found that expansions of public coverage were accompanied by reductions in private coverage. Some even found that enrollment growth in public programs was completely offset by reductions in private coverage.²⁹

Medicaid also discourages private insurance for nursing home and other long-term care expenses. Jeffrey Brown of the University of Illinois at Urbana-Champaign and Amy Finkelstein of the National Bureau of Economic Research found that 60 to 75 percent of the benefits from private long-term care insurance “are redundant of benefits that Medicaid would otherwise have paid.” They estimate that Medicaid by itself discourages 66 percent to 90 percent of

seniors from purchasing such insurance.³⁰

States

Medicaid also induces responses by states that increase both the seen and the unseen costs of the program. Whatever costs Medicaid imposes grow with the program’s size and scope. Program attributes that affect its scope, then, may be considered contributors to Medicaid’s unseen costs.

Any state can at least double its money by increasing its Medicaid contribution and obtaining matching federal funds. Some states, such as Arkansas, Mississippi, New Mexico, and West Virginia, can triple their money. In certain cases, states have even been able to use federal funds to supplant completely funds that they would have appropriated themselves.

The federal government’s open-ended commitment to match state Medicaid spending alters a state’s incentive to fund Medicaid relative to other priorities. States receive an average of \$1.30 from Washington for every dollar they spend. Spending \$1 on police buys \$1 of police protection, but spending \$1 on Medicaid buys \$2.30 of health care. This encourages states to expand Medicaid even beyond what is necessary to assist the truly needy. According to the Urban Institute, about one-fifth of adults and children who are eligible for Medicaid nonetheless obtain private coverage.³¹ The fact that some 20 percent of those who fall within states’ Medicaid eligibility criteria can obtain private coverage suggests that many who are actually enrolled in Medicaid would be able to obtain private coverage. That strongly suggests that states have expanded Medicaid beyond its original purpose of providing medical assistance to the truly needy.

States have also used numerous accounting schemes to secure federal matching funds, which are then diverted from their Medicaid programs toward other items.³² For example, the DSH program was created to provide additional federal funding to hospitals that treat a large number of uninsured patients.

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Yet DSH funds do not necessarily increase overall funding for uncompensated care. In fact, they often displace existing efforts. Mark Duggan studied California's Medicaid DSH program and found that in 1990 "every dollar of DSH funds crowds out one dollar of [local] government subsidies."³³ Surveys have found that as much as one-third of federal DSH payments were captured by states and spent on other items.³⁴

As one might expect, when such funds are diverted from the provision of medical care, they do little to improve health. According to Dartmouth economists Katherine Baicker and Douglas Staiger, "Surprisingly little is known about whether these public subsidies have had any impact on patient care, despite spending of nearly \$200 billion during the 1990s on these programs by state and federal governments."³⁵ Duggan finds that "virtually none of the billions of dollars received by these facilities results in improved medical care quality for the poor."³⁶ He concludes that "health outcomes for low-income individuals did not improve despite a substantial increase in public medical spending for the indigent. . . . If California's experience is representative of the U.S. as a whole, then the social benefit from this \$20 billion increase in public medical spending has been much smaller than its cost."³⁷

Medicaid funds diverted from medical care do not lose all value. Baicker and Staiger note that those funds "may result in other benefits to society . . . such as tax abatement or subsidies of other government programs."³⁸ However, the convoluted path those funds take results in unnecessary inefficiency and may do little to achieve Medicaid's purpose of improving the health of the truly needy.

Taxpayers

Medicaid induces costly responses on the part of taxpayers who fund the program as well. Those unseen costs stem from Medicaid's tax burden and the resulting effect on taxpayers' work incentives; its effect on the cost of private medical care and health insurance; and its

effect on charitable activity to provide medical care to the poor.

Perhaps the easiest donor cost to quantify is the tax burden imposed by Medicaid. With Medicaid spending projected at \$309 billion, the program's per capita cost exceeded \$1,000 in 2004.³⁹ (That figure does not include hidden costs of the program, including Medicaid's effect on the cost of private medical care.) A tax burden of this magnitude decreases the rewards of productive activity.

How the tax burden of Medicaid is distributed will determine whether (and to what extent) it creates a disincentive to work for the poor or for the nonpoor. If the tax burden is disproportionately imposed on higher-income earners, high marginal tax rates will reduce work incentives for those individuals. Insofar as it is placed on lower-income individuals, Medicaid will place a significant obstacle in the way of the poor who would like to pull themselves out of poverty.

The tax burden that Medicaid places on low-income earners should not be taken lightly. Generally, those with higher incomes pay for a larger share of Medicaid spending as a result of their greater consumption and larger incomes (which are taxed at higher marginal income tax rates). However, 43 percent of Medicaid revenues come from state governments. On average, states rely on general sales taxes for one-third of general fund revenues.⁴⁰ Sales and gross receipt taxes account for half of overall state revenues.⁴¹ Sales taxes are widely considered regressive in that they place a larger burden on low-income earners relative to income. In addition, personal income taxes provide one-third of state revenues and also place a significant burden on low-income families.⁴² That observable cost imposes unseen costs by discouraging and frustrating self-help among actual and potential Medicaid recipients, just as the availability of the subsidy does.

As discussed below, Medicaid effectively increases the cost of privately purchased medical care and health insurance. Insofar as Medicaid discourages individuals from obtaining private health insurance, it diminishes the ability of private insurers to pool

risk, and thus may further increase the cost of private health insurance. That in turn encourages greater Medicaid enrollment and increases the likelihood that those ineligible for Medicaid will lack coverage and rely on emergency rooms and other providers for uncompensated care.

Finally, Medicaid's significant tax burden makes nonrecipients less able—and perhaps less willing—to provide charitable assistance to those in need of medical care. Just as means-tested government subsidies discourage self-help by recipients, they discourage charitable efforts by donors. A study by Jonathan Gruber and Daniel Hungerman found that, although churches were “a crucial provider of social services through the early part of the twentieth century,” churches' charitable activities fell by nearly one-third as a result of increased relief spending under the New Deal.⁴³ By providing medical care to 50 million Americans at a cost of more than \$1,000 per capita, Medicaid likely crowds out significant amounts of charitable care, either because individuals are less able to give because of Medicaid's tax burden or because they believe the problem is taken care of.

Overconsumption of Medical Care

A number of Medicaid's unseen costs result from overuse of medical care by recipients. The program typically offers services to beneficiaries free of charge. That encourages beneficiaries to consume medical care without regard to its cost. A patient in this position will keep consuming costly medical care even though she receives little benefit from it. Such overuse diverts money from more productive uses, such as medical care that would have benefited someone else.

Overuse can lead to a significant waste of health resources. The RAND Health Insurance experiment observed use by individuals for whom health care was made “free” compared with use by those who faced tradeoffs between medical care and other items for the

first few thousand dollars of medical expenses. The researchers demonstrated that availability of “free” medical care encouraged individuals to consume an average of 43 percent more care but failed to produce measurable overall health gains.⁴⁴

Though Medicaid allows millions of Americans to consume medical care free of charge, data on the extent of over-utilization and its costs are scarce. Nonetheless, the Medicare program can provide some insight into the amount of unnecessary care purchased by Medicaid. Medicare subsidizes care for a similar number of individuals, many of whom are insensitive to price. Researchers at Dartmouth College have found that “nearly 20 percent of total Medicare expenditures . . . appears to provide no benefit in terms of survival, nor is it likely that this extra spending improves the quality of life.”⁴⁵ That is a conservative estimate of overuse, as it includes only care that provides no value; it does not account for care that provides some benefit, but less benefit than its cost. If overuse in Medicaid were of the same order of magnitude as in Medicare, its cost would be in the tens of billions of dollars each year.⁴⁶

Overuse affects, and is affected by, other costs of the program. For example, encouraging 50 million Americans to consume care with little regard to cost increases demand for medical services. That in turn should result in higher prices for medical services. Not only does overuse make medical care more costly for both public and private payers, but higher prices for private care make Medicaid a more attractive option than private coverage. Yet rising medical prices are rarely seen as a consequence of Medicaid's effect on demand for medical services.

Price Controls

Medicaid's administered prices act as price controls. Medicaid typically pays doctors at below-market rates for covered services. As an illustration, Medicare's physician reimbursement rates are widely considered to

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be below market-clearing levels. In 1993 Medicare payments for physicians' services came to just over 60 percent of the average rate paid by private insurers; by 2003 that ratio had risen to just over 80 percent.⁴⁷ Yet Medicaid pays doctors even less. In 1998 a doctor who treated a Medicaid patient would receive on average 62 percent of what she would receive for treating a Medicare patient.⁴⁸

One unseen cost of Medicaid's price controls is common to all price ceilings. Those subjected to the artificially low price take steps to subvert the controls. One example is Medicaid-participating physicians' greater likelihood to manipulate reimbursement rules. Research suggests that 39 to 50 percent of physicians have manipulated third-party reimbursement rules in order to obtain coverage for an otherwise uncovered service or to increase the amount the physician is paid.⁴⁹ Doctors whose patient base is at least 25 percent Medicaid patients are much more likely to get around such controls by manipulating reimbursement rules.⁵⁰

Some of the hidden costs imposed by Medicaid's price controls are borne by private payers. One example occurs with Medicaid payments for prescription drugs. Medicaid's drug price controls result in the program paying about 90 percent of the average price paid by private purchasers. In addition, Medicaid holds any increases in payments to the overall rate of inflation. Mark Duggan of the University of Maryland and Fiona Scott Morton of Yale University find that this effectively increases the price of non-Medicaid prescriptions by 13.3 percent over and above what they otherwise would be.⁵¹ Thus, if a regime of medications costs a private payer \$1,000 per year, over \$117 of that cost is effectively a hidden tax attributable to Medicaid.

Like overuse, this influences other costs imposed by Medicaid. Increasing the cost of private medical care necessarily increases the cost of private health insurance, which makes Medicaid a more attractive option for those who are already eligible or are on the cusp of eligibility. That is likely to lead to greater enrollment and dependence.

Quality

Another unseen cost of Medicaid is the costs borne by patients who receive lower-quality care than they would receive from private alternatives that they might choose if Medicaid were not an option. Mutual aid is one such alternative, as is commercial health insurance. How does Medicaid compare with these alternatives in terms of quality?

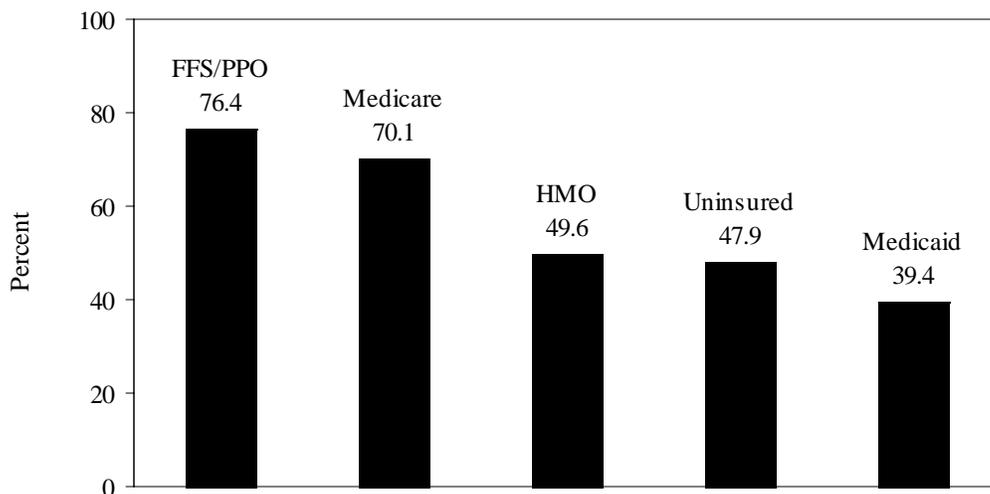
Choice of Providers

A patient's choice of providers is one dimension of health coverage quality. One survey found the strongest predictor of dissatisfaction with a health plan, as measured by unwillingness to recommend the plan to others, is lack of choice with respect to providers.⁵² Lack of choice also influences the quality of care. If a patient is unhappy with the care he or she is receiving from one physician, the quality of that care will improve if there are other options available. The patient is more likely to find a provider who meets his or her needs, and providers are more likely to compete with each other to do so.

Physicians unwilling to accept Medicaid's low reimbursement rates as payment in full must refuse Medicaid patients. As a result, many doctors do so. As one study notes, "Physicians in states with the lowest Medicaid fees were less willing to accept most or all new Medicaid patients in both 1998 and 2003."⁵³ That significantly restricts Medicaid patients' choice of providers.

Medicaid patients often see their physician choices narrow even when payments to physicians rise. From 1998 to 2003 states increased physician payments by twice the rate of inflation.⁵⁴ Yet Medicaid patients still saw their choice of providers drop. The share of doctors accepting all new Medicaid patients fell from 48.1 percent to 39.4 percent from 1999 to 2002. In contrast, far more doctors accepted all new private fee-for-service (FFS) and preferred provider organization (PPO) patients, Medicare patients, non-Medicaid health maintenance organization (HMO) patients,

Figure 2
Quality of Care: Share of Doctors Accepting All New Patients, by Coverage Type, 2002



Source: Julie A. Schoenman and Jacob J. Feldman, “2002 Survey of Physicians about the Medicare Program,” Project HOPE Center for Health Affairs, no. 03–1, March 2003, p. 43.

and uninsured, self-pay, and charity patients (see Figure 2). The share of doctors accepting no new Medicaid patients increased from 26.4 percent to 30.5 percent over the same period, yet far fewer doctors refused to see patients with the other types of coverage (see figure 3).⁵⁵ As Oregon’s Medicaid bureaucracy acknowledged in 2001, “Having coverage does not always guarantee access.”⁵⁶

The limited availability of providers and other factors affect Medicaid patients’ ability to obtain medical care and can leave patients who might otherwise obtain private coverage worse off. For example, adults who are eligible for Medicaid but have *private* coverage have fewer unmet medical needs than eligible adults who are enrolled in the program.⁵⁷

The unseen costs of Medicaid’s poor quality of care fall hardest on women. Medicaid subsidizes health care for 1 of 10 American women, who comprise 71 percent of adult beneficiaries.⁵⁸ Women with Medicaid coverage have more difficulty finding a doctor than uninsured women and significantly more difficulty than women with private coverage. They are twice as likely as women with private coverage to have difficulty obtaining

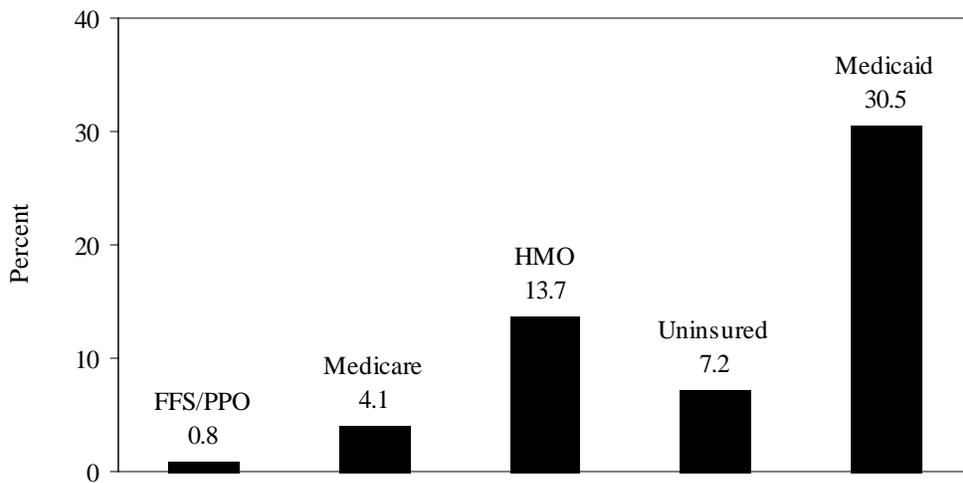
care due to a lack of doctors or clinics.⁵⁹

Does Medicaid Improve Health?

Medicaid provides necessary and often emergent medical care to millions of recipients. However, a number of studies question whether the quality of care provided improves health as much as private alternatives. A 1999 study by the National Bureau of Economic Research observed that “relatively little is known about the effects of Medicaid on health outcomes.”⁶⁰ The authors note that “[f]indings from studies of Medicaid’s effect on infant health are inconclusive.”⁶¹ Although the authors had set out to quantify the health benefits of Medicaid coverage, they found “at best weak support for the hypothesis that Medicaid improves the health of low-income children.”⁶² They concluded, “The proposition that health insurance is the cure for adverse health outcomes among poor and near-poor children has not been adequately demonstrated.”⁶³ Regarding the creation of the State Children’s Health Insurance Program, through which the federal government spent \$24 billion with the stated purpose of improving the health of low-income children, the authors commented, “It is remarkable that

Adults who are eligible for Medicaid but have *private* coverage have fewer unmet medical needs than eligible adults who are enrolled in the program.

Figure 3
Quality of Care: Share of Doctors Accepting No New Patients, by Coverage Type, 2002



Source: Julie A. Schoenman and Jacob J. Feldman, “2002 Survey of Physicians about the Medicare Program,” Project HOPE Center for Health Affairs, no. 03-1, March 2003, p. 43.

there is so little empirical evidence to support so large an expenditure.”⁶⁴

A study by researchers at Stanford University and the RAND Corporation found that HIV patients with health coverage are less likely to die prematurely, “but private insurance is more effective than public coverage. The better outcomes associated with private insurance are attributable to the more restrictive prescription drug policies of Medicaid.”⁶⁵ The authors write:

Some private insurers may place limits on when it [sic] will cover [highly active anti-retroviral therapy, or HAART], but Medicaid limits can be quite severe. Many states place limits on how many prescriptions can be filled per month, and since HAART therapy alone averages 4.8 prescriptions, these can limit coverage for not only HAART but also drugs to treat opportunistic infections associated with advanced disease. Many of the drugs also required prior authorization that restricted use to advanced illness. The result is that privately insured patients are able to start treatment earlier in the disease than

the publicly insured, and the latter often have no coverage at all.⁶⁶

Insofar as beneficiaries (whether HIV patients or others) substitute Medicaid for private health coverage, the program may actually reduce the quality of care they receive—another unseen cost of Medicaid.

Insofar as beneficiaries substitute Medicaid for private health coverage, the program may actually reduce the quality of care they receive.

How to Reduce All Medicaid Costs, Seen and Unseen

What can be done to minimize the costs imposed by Medicaid, both seen and unseen? One set of options would restructure the program. Those options include altering how the program is financed or the way benefits are delivered.

Block Grants

One way to reform Medicaid’s financing structure would be to “block grant” federal funding. Under such proposals, the federal government would no longer offer states an open-ended “match” of state funds. Instead,

the federal Medicaid contribution would be independent of each state's contribution. This change would eliminate the existing incentive states face to "double their money" by expanding Medicaid benefits or eligibility. As noted earlier, there are strong indications that Medicaid eligibility has expanded beyond the truly needy, which has increased the program's seen and unseen costs. Block grants would reduce those costs and encourage states to target scarce resources to the truly needy.

In 1981, 1995, and 2003, proposals to block grant federal Medicaid funding received national attention. Each proposal sought to cap federal funding and give states broader flexibility to administer their programs. However, none of them was successful. Block grant proposals offered by Presidents Reagan and George W. Bush died in Congress in 1981 and 2003. A Republican block grant proposal passed Congress in 1995 but was vetoed by President Clinton.

Health Savings Accounts and Vouchers

Other observers have proposed restructuring the way Medicaid provides benefits. One such proposal would make use of health savings accounts (HSAs), while others would give beneficiaries a voucher to purchase private health insurance.

Some governors, such as Florida's Jeb Bush and South Carolina's Mark Sanford, have proposed restructuring Medicaid for some beneficiaries to include HSAs. Instead of an open-ended promise of health benefits, beneficiaries would receive money in an HSA to use toward copayments and deductibles and could keep what they didn't spend. The idea behind HSAs is to give beneficiaries an incentive to be prudent consumers, and it builds on what seem to be successful "cash and counseling" programs in Florida, Arkansas, and New Jersey.⁶⁷

Medicaid HSAs could be used independent of or in tandem with Medicaid vouchers. Giving eligible individuals a voucher that they could put toward the cost of private health insurance premiums would provide beneficiaries much greater choice of cover-

age, and they could expect a much higher level of quality. In addition, beneficiaries would be more careful shoppers if they shared in the savings.

However, the availability of a more attractive Medicaid subsidy would not eliminate the perverse incentives created by the subsidy's existence. In fact, it could heighten them. All subsidies increase the incidence of that which is subsidized and become even more attractive the more control they grant the recipient. HSAs and vouchers would give Medicaid enrollees greater control over their subsidy, since each operates more like cash than traditional Medicaid benefits. The very fact that these reforms would give beneficiaries greater control over their subsidy would lead to a different—and possibly more harmful—mix of seen and unseen costs.

For example, Medicaid HSAs and vouchers would encourage more eligible individuals to claim their subsidies. Only about two-thirds of Medicaid-eligible individuals are actually enrolled at a given time.⁶⁸ Moreover, recipients likely would remain enrolled for longer periods, whereas now many beneficiaries use Medicaid for only brief periods. That may have been part of the reason Florida's "cash and counseling" program saw increased outlays in its first year of operation.⁶⁹ Altering Medicaid subsidies to more closely resemble cash thus could increase the program's tax burden, heighten the disincentives to work, exacerbate its crowd-out effects, and increase dependence.

It is by no means certain that Medicaid HSAs or vouchers would produce a worse state of affairs than Medicaid's existing benefits structure. States should be free to experiment with such approaches and to learn from each other's successes and failures. However, simply changing the structure of Medicaid's subsidies is unlikely to reduce the program's seen and unseen costs.

Withdrawing Assistance

An option for reducing the costs imposed by Medicaid that is discussed less often is withdrawing assistance from those who are best able to obtain medical care and coverage

Altering Medicaid subsidies with HSAs or vouchers could increase the program's tax burden, heighten the disincentives to work, exacerbate its crowd-out effects, and increase dependence.

One reform that must be considered is disenrolling those beneficiaries most likely to land on their feet.

elsewhere. As noted earlier, one-fifth of Medicaid-eligible individuals are able to obtain private coverage. Although this could represent the entire population of those who are able to obtain private coverage, the literature on work disincentives, price controls, and crowd-out suggests it does not. The available evidence suggests Medicaid encourages individuals to avoid self-help and mutual help, makes self-help more difficult for those who attempt it, and ultimately succeeds in getting those with other options to become dependent on Medicaid. Thus, one reform that must be considered is disenrolling those beneficiaries most likely to land on their feet. Doing so would increase work incentives for those individuals, reduce dependence, make private health coverage more affordable, and reduce the tax burden of Medicaid.

States have already begun that process out of necessity. The federal government should give states greater flexibility to return Medicaid to its original mission of providing a safety net for the truly needy.

Evidence from Welfare Reform

What would be the effects of withdrawing Medicaid assistance from some recipients? The 1996 welfare reform law provides an instructive lesson. The now-repealed Aid to Families with Dependent Children cash assistance program operated like Medicaid in many ways. Both programs conferred a legal entitlement to benefits for anyone who meets the eligibility criteria. Each received funding from the federal government in the form of an open-ended “match.” And each was largely run from Washington, which issued detailed rules on how states should manage their programs.

AFDC had been accused of discouraging work and encouraging dependence. The 1996 welfare reform law sought to minimize that program’s seen and unseen costs by scaling back federal cash assistance for the poor. Congress eliminated the federal entitlement to benefits and put in its place a five-year lifetime limit on benefits plus work requirements for many recipients; block-granted

federal funding; and gave states greater control over eligibility, benefits, and the use of federal funds.

Opponents of the 1996 law predicted that scaling back federal assistance in that way would be disastrous for the poor. Some predicted that an additional one million children would be thrown into poverty.⁷⁰ Yet withdrawing assistance produced exactly the opposite result. Caseloads plummeted and poverty decreased—often dramatically—for every racial category and age group, including children. Although the poverty rate has increased somewhat in recent years, it remained lower in 2003 than at any point in the 17 years leading up to welfare reform.⁷¹

Although the robust economy of the 1990s contributed to those outcomes, its effect was relatively small. A study by former Congressional Budget Office director June O’Neill and Anne Hill indicates that TANF “accounts for more than half of the decline in welfare participation and more than 60 percent of the rise in employment among single mothers,” while “the booming economy of the late 1990s . . . account[ed] for less than 20 percent of either change.”⁷² Many who opposed the 1996 law have since admitted that it accomplished a large measure of good.

The experience of welfare reform suggests that means-tested government cash assistance programs impose unseen costs in the form of dependence and diminished effort, and that scaling back that assistance produced positive results. But would the same hold for Medicaid? A provision of the 1996 welfare reform law suggests that it might.

Evidence Regarding Medicaid

Wholesale Medicaid reform was dropped from the welfare reform law in 1996. However, that law contained a little-noticed provision that eliminated Medicaid eligibility for many immigrants. Harvard economist George Borjas studied the outcome of that provision. He found that the result of that “draconian” measure was exactly the opposite of what many would predict: health coverage among noncitizen immigrants *increased*.

After Congress cut off Medicaid benefits for immigrants, a number of states responded with programs to preserve coverage for those affected. Borjas examined the coverage rates for affected immigrants with the expectation that “as the Medicaid cutbacks took effect, the proportion of those immigrants covered by some type of health insurance should have declined.” To the contrary, he found that “the expected decline in health insurance coverage rates did not materialize. If anything, health insurance coverage rates actually rose slightly in this group.” Borjas explained:

The resolution to this conflicting evidence lies in the fact that the affected immigrants responded to the welfare cutbacks. The immigrants most likely to be adversely affected by the new restrictions significantly increased their labor supply, thereby raising their probability of being covered by employer-sponsored insurance. In fact, this increase in the probability of coverage through employer-sponsored insurance was large enough to completely offset the Medicaid cutbacks. The empirical analysis, therefore, provides strong evidence of a sizable crowd-out effect of publicly provided health insurance among immigrants. *In an important sense, the state programs were unnecessary.* In the absence of these programs, the targeted immigrants themselves would have taken actions to reduce the probability that they would be left without health insurance coverage.⁷³

The robust economy of the late 1990s cannot explain those results, Borjas argues, because states that offered coverage to people cut from the Medicaid rolls saw coverage levels for this group decrease, whereas states that did not saw coverage levels increase:

The rate of ESI [employer-sponsored insurance] coverage for non-citizens rose 2.7 percentage points in the more generous states, and by an astounding 11.4

percentage points in the less generous states. The descriptive evidence . . . suggests a causal relationship between the Medicaid cutbacks and the use of ESI coverage in the targeted population.⁷⁴

Borjas notes that immigrants responded not just to the Medicaid cuts but to all the changes in the 1996 law. Nonetheless, a natural experiment has revealed that Medicaid cuts produced results consistent with those of the broader welfare reforms, and exactly the opposite of what many would predict. Moreover, if the state programs designed to protect immigrants from losing coverage were unnecessary, it follows that so too were the original Medicaid subsidies.

Borjas’s research demonstrates that Medicaid requires taxpayers to pay the health care bills of some of those who could obtain health coverage on their own. And it suggests that withdrawing that assistance need not decrease—and could instead increase—coverage levels.

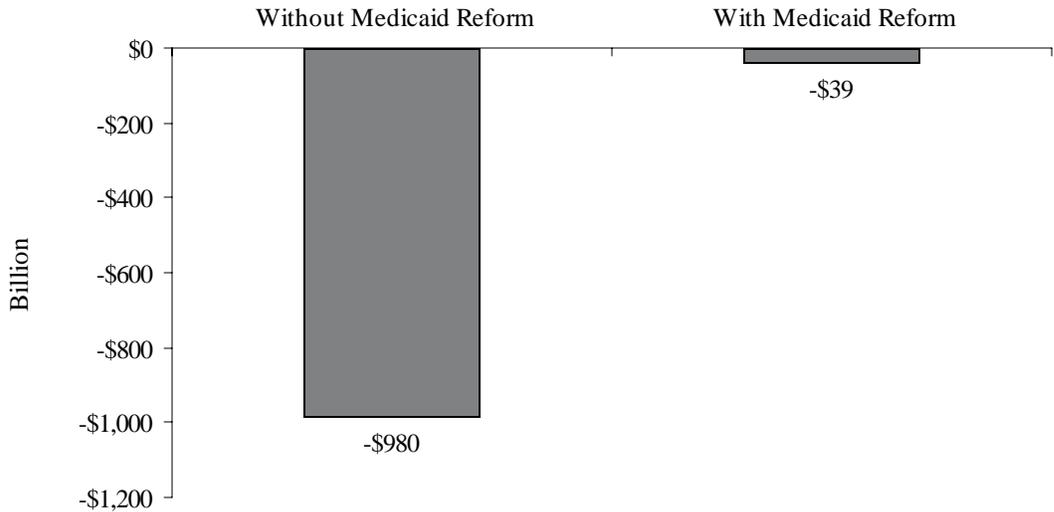
An Agenda for Medicaid Reform

America’s experience with welfare reform provides a model for reducing both the seen and unseen costs by Medicaid. First, Congress should stop encouraging Medicaid expansions by freezing payments to states at the 2005 amount, just as welfare reform froze payments to states at the 1995 amount. According to Congressional Budget Office figures, freezing federal Medicaid spending at 2005 levels could produce \$941 billion in savings by 2015, or enough to erase 96 percent of the cumulative 10-year federal deficit (see Figure 4).⁷⁵ Second, Congress should give states maximum flexibility to use federal funds to meet a few broad goals, as it did with AFDC’s replacement, the TANF program. Those goals could consist of the following:

1. targeting medical assistance to the truly needy;

When the welfare reform law eliminated Medicaid eligibility for many immigrants, health coverage among noncitizen immigrants increased.

Figure 4
Cumulative Budget Deficit, 2006–2015



Source: *The Budget and Economic Outlook: Fiscal Years 2006 to 2015* (Washington: Congressional Budget Office, January 2005), p. 56; *An Analysis of the President’s Budgetary Proposals for Fiscal Year 2006* (Washington: Congressional Budget Office, March 2005), p. 24; and author’s calculations.

2. reducing dependence;
3. reducing crowd-out of private effort, including charitable care; and
4. promoting competitive private markets for medical care and insurance.

A necessary first step toward allowing states to focus resources on the truly needy would be to eliminate the federal entitlement to Medicaid benefits—just as Congress eliminated the federal entitlement to cash assistance under TANF—and allow each state to determine eligibility and benefits in its own program.

By themselves, these reforms would not alter a single state’s program. Each state would have the power to keep operating its Medicaid program under the same eligibility and benefits rules as today. States that want to spend more on their Medicaid programs would be free to do so. However, states likely would experiment with ways of providing efficient care to the truly needy and encouraging private charitable care. Today, states are learning from each other’s efforts at encouraging work and reducing dependence through their TANF programs. These

reforms would allow states to engage in the same discovery process with Medicaid. As states learn from each others’ experiences, they would imitate successful approaches to reducing Medicaid dependence, health care costs, and the burden Medicaid imposes on taxpayers.

The available literature suggests that returning Medicaid to its intended role as a safety net for the truly needy would require removing many beneficiaries from the program. That begs the question: whom should states cut loose? The answer likely will be different for each state. Obviously, states should focus on those who are most likely to land on their feet. A prime target would be well-to-do families who are financially able to purchase private long-term-care insurance but who nonetheless use Medicaid to pay for nursing home and other long-term care. With full flexibility to define eligibility, states would no longer be forced to scale back eligibility for only “optional” beneficiaries. Instead, each state could decide for itself which individuals are most deserving of government assistance.

Congress should freeze payments to states at the 2005 amount and give states maximum flexibility to use federal funds to meet a few broad goals.

To make medical care more accessible to those no longer enrolled in Medicaid, states should deregulate provider and health insurance markets. States should begin by relaxing or repealing laws (such as coverage mandates and pricing restrictions) that increase the cost of private health insurance. One way to do so would be to allow individuals and employers to avoid unwanted regulatory costs by purchasing health insurance across state lines. States should also relax laws (such as those that restrict tele-medicine, scope of practice, and provider mobility) that inhibit the ability of health care providers to provide affordable care to underserved communities. For its part, the federal government can encourage affordability and competition by allowing interstate commerce in health insurance and making health savings accounts more widely available in the private sector.⁷⁶

Opponents will argue that individuals who move from Medicaid to private insurance will end up with less coverage. As noted earlier, that is less than certain. But how a person obtains coverage can be just as important as how much coverage he or she has. When someone with private coverage works hard to increase earnings, society benefits from the effort and the individual benefits from the added income. By contrast, someone with Medicaid coverage who works hard and increases earnings often ends up no better off, or even worse off. Offering people Medicaid coverage in lieu of private coverage conveys that the way to get more is by doing less: work less, save less, cultivate less self-reliance. Like other means-tested government programs, Medicaid sets a trap for the poor; that trap should be avoided whenever possible.

Conclusion

Medicaid imposes significant costs in addition to the tax revenue it spends. Medicaid encourages people to become dependent on government; encourages people to behave in ways that increase the cost of government and

of medical care, which makes self-reliance more difficult for others; and encourages states to induce more people to impose those costs on their neighbors. Medicaid provides needed medical care to many Americans, but often at a lower level of quality than the private coverage it places beyond their reach. Cost-containment efforts should focus on all costs imposed by Medicaid, seen and unseen.

With so many similarities between Medicaid and the old AFDC program, Congress should reform Medicaid along the same lines as it reformed welfare: end the entitlement to benefits; eliminate states' open-ended entitlement to matching federal funds; cap federal payments to the states; and give states maximum flexibility to pursue a few broad goals. The surest way to reduce Medicaid costs—seen and unseen—is to withdraw assistance from those who are most able to obtain coverage elsewhere.

Providing efficient medical care to the poor without fostering dependence is a delicate balancing act, and many of the costs incurred by getting it wrong don't get a line item in the federal budget. Reforming Medicaid along the lines of the 1996 welfare law would allow the states to strike a better balance for all involved.

Notes

1. In addition to the 50 states and the District of Columbia, the following territories operate their own Medicaid programs: American Samoa, the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands.
2. "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2004 through September 30, 2005," *Federal Register* 68, no. 232 (December 3, 2003): 67676-78, <http://aspe.hhs.gov/health/fmap05.htm>.
3. "For example, the states are prohibited by federal law from charging beneficiaries more than nominal copayments for services." Jeanne M. Lambrew, "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals," *Milbank Quarterly* 83, no. 1 (January 26, 2005): 44.

Like other means-tested government programs, Medicaid sets a trap for the poor; that trap should be avoided whenever possible.

4. "The Medicaid Program at a Glance," Kaiser Commission on Medicaid and the Uninsured, January 2004.
5. John D. Klemm, "Medicaid Spending: A Brief History," *Health Care Financing Review* 22, no. 1 (Fall 2000): 106, <http://www.cms.hhs.gov/review/00fall/00Fallpg105.pdf>.
6. Donna Cohen Ross and Laura Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families," Kaiser Commission on Medicaid and the Uninsured, October 2004, p. 2.
7. National Association of State Budget Officers, "2003 State Expenditure Report," October 2004, p. 46.
8. Vernon Smith et al., "States Respond to Fiscal Pressure: A 5-State Update of State Medicaid Spending Growth and Cost Containment Actions," Kaiser Commission on Medicaid and the Uninsured, January 2004; and "States Continue to Face Budget Problems, but Continue to Meet Their Safety Net Role," Bureau of National Affairs *Health Care Policy Report* 12, no. 40 (October 11, 2004): 1398.
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10. Shaila Dewan, "In Mississippi, Soaring Costs Force Deep Medicaid Cuts," *New York Times*, July 2, 2005, <http://www.nytimes.com/2005/07/02/national/02medicaid.html>.
11. Kelly Wiese (Associated Press), "Judge Denies Move to Block Medicaid Cuts," *Belleville News-Democrat*, July 1, 2005, <http://www.belleville.com/mld/belleville/news/local/12028251.htm>.
12. Tim Hoover, "System Will Be Restructured; Missouri Medicaid Panelists Start Task," *Kansas City Star*, June 29, 2005, <http://www.kansascity.com/mld/kansascity/living/health/12009243.htm>.
13. National Association of State Budget Officers, p. 2.
14. National Association of State Budget Officers, pp. 16, 47, 49. This does not include an estimated \$6.1 billion in State Children's Health Insurance Program expenditures in 2004 (p. 101).
15. National Association of State Budget Officers, p. 46.
16. Medicaid Commission charter, Center for Medicare and Medicaid Services, May 19, 2005, <http://www.cms.hhs.gov/faca/mc/charter.pdf>.
17. Aaron S. Yelowitz, "Evaluating the Effects of Medicaid on Welfare and Work: Evidence from the Past Decade," Employment Policies Institute, December 2000, p. iv.
18. *Ibid.*, p. 2.
19. *Ibid.*, p. 9.
20. Yelowitz, p. 4. For an example of how this disincentive affects work decisions, see Philip Dawdy, "Give Them Shelter," *Seattle Weekly*, May 5, 2004, p. 22.
21. Jonathan Gruber and Aaron Yelowitz, "Public Health Insurance and Private Savings," *Journal of Political Economy* 107, no. 6, part 1 (December 1999): 1259.
22. *Ibid.*, pp. 1249–74.
23. Ross and Cox, p. 43.
24. "Medicaid limits non-exempt assets for [long-term care] recipients to \$2,000. But exempt assets are unlimited. For example, a home and all contiguous property, a business including the capital and cash flow, and one automobile, all of unlimited value plus many, many other resources are excluded from eligibility asset limits . . . Medicaid planners use both simple sophisticated techniques to protect additional hundreds of thousands of dollars for affluent clients and their heirs. Such techniques include gifting strategies, annuities, trusts, life care contracts and dozens of others delineated in hundreds of law journal and popular media articles and books." Stephen A. Moses, "How to Save Medicaid \$20 Billion per Year and Improve the Program in the Process," Center for Long-Term Care Financing, January 5, 2005, p. 2.
25. David T. Beito, *From Mutual Aid to the Welfare State: Fraternal Societies and Social Services, 1890–1967* (Chapel Hill: University of North Carolina Press, 2000), p. 2.
26. *Ibid.*, p. 203.
27. *Ibid.*, p. 198.
28. Moreover, recent research corroborates that free clinics also have a crowd-out effect on private health insurance. Anthony T. Lo Sasso and Bruce D. Meyer, "The Health Care Safety Net and Crowd-Out of Private Health Insurance," Joint Center for Poverty Research Working Paper, May 2003, p. 18.
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Research Synthesis Report no. 5, June 2004. This survey reports on 22 studies examining crowd-out effects of public insurance, with results ranging from no evidence of crowd-out to crowd-out levels as high as 177 percent of increased enrollment in public programs.

30. Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," NBER Working Paper no. 10989, December 2004, pp. 2-3.

31. Twenty-one percent of Medicaid-eligible adults and 27 percent of Medicaid-eligible children are reported to have private coverage. Amy J. Davidoff, Bowen Garrett, and Alshadye Yemane, "Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need?" Urban Institute Policy Brief, series A, no. A-48, October 1, 2001, p. 2; and Amy J. Davidoff, Bowen Garrett, and Matthew Schirmer, "Children Eligible for Medicaid but Not Enrolled: How Great a Policy Concern?" Urban Institute Policy Brief, series A, no. A-41, September 1, 2000, pp. 1-2. The latter study reports, "Dual Medicaid and privately insured children were counted in the privately insured category," but does not state what portion of the privately insured category these "duals" represent.

32. Katherine Baicker and Douglas Staiger, "Fiscal Shenanigans, Targeted Federal Health Care Funds, and Patient Mortality," NBER Working Paper no. 10440, April 2004, p. 1; Teresa A. Coughlin, Leighton Ku, and Johnny Kim, "Reforming the Medicaid Disproportionate Share Hospital Program," *Health Care Financing Review* 22, no. 2 (Winter 2000): 1; and Kathryn G. Allen, associate director, Health Financing and Public Health Issues; Health, Education, and Human Services Division; General Accounting Office, "Medicaid: State Financing Schemes Again Drive Up Federal Payments," Statement before the Senate Committee on Finance, GAO/T-HEHS-00-193, September 6, 2000.

33. Mark Duggan, "Hospital Ownership and Public Medical Spending," NBER Working Paper no. 7789, July 2000, p. 27.

34. Coughlin, Ku, and Kim, p. 1.

35. Baicker and Staiger, p. 1.

36. Duggan, p. 27.

37. *Ibid.*, p. 26.

38. Baicker and Staiger, p. 30.

39. The term "donor" may be inappropriate when discussing government anti-poverty efforts, contributions to which are compulsory. The term is used

here to denote both willing and unwilling donors. Aggregate Medicaid spending in 2004 reached an estimated \$309 billion, which represents more than \$1,000 for each of the 294 million U.S. residents. National Association of State Budget Officers, p. 47; and U.S. Census Bureau, "Table 1: Annual Estimates of the Population for the United States and States, and for Puerto Rico: April 1, 2000 to July 1, 2004," December 22, 2004, p. 1.

40. National Association of State Budget Officers, pp. 16, 94.

41. U.S. Census Bureau, "State Government Tax Collections: 2004," <http://www.census.gov/govs/statetax/0400usstax.html>.

42. "For example, a two-parent family of four in Alabama with income of \$19,311—the 2004 poverty line for a family that size—owes \$513 in income tax, while such a family in Hawaii owes \$434 and in Arkansas \$403. Such amounts can make a big difference to a struggling family." Joseph Llobrera and Robert Zahradnik, "The Impact of State Income Taxes on Low-Income Families in 2004," Center on Budget and Policy Priorities, April 12, 2005.

43. Jonathan Gruber and Daniel M. Hungerman, "Faith-Based Charity and Crowd-out During the Great Depression," NBER Working Paper no. 11332, May 2005, abstract at <http://www.nber.org/papers/w11332>.

44. Joseph P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Boston: Harvard University Press, 1996), pp. 338-39.

45. Jonathan Skinner, Elliott S. Fisher, and John E. Wennberg, *The Efficiency of Medicare*, NBER Working Paper no. 8395, 2001.

46. This estimate is less than scientific. A number of differences between these programs might prohibit applying the overconsumption estimates of Medicare to Medicaid. For example, as noted earlier, Medicaid patients are much younger than Medicare patients. Having less interaction with the health care system generally, Medicaid patients would presumably have fewer opportunities to overuse care. On the other hand, cost-sharing requirements in each program may leave Medicare patients more sensitive to price. More important than this rough estimate's precision is its order of magnitude.

47. Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2005, p. 78.

48. Stephen Zuckerman et al., "Changes in Medicaid

- Physician Fees, 1998–2003: Implications for Physician Participation,” *Health Affairs* Web Exclusive, June 23, 2004, p. W4-374, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1.pdf>.
49. Sidney T. Bogardus Jr., David E. Geist, and Elizabeth H. Bradley, “Physicians’ Interactions with Third-Party Payers: Is Deception Necessary?” *Archives of Internal Medicine* 164 (September 27, 2004): 1841–44.
50. Matthew K. Wynia et al., “Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place,” *Journal of the American Medical Association* 283, no. 14 (2000): 1864.
51. Mark Duggan and Fiona Scott Morton, “The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing,” NBER Working Paper no. 10930, November 2004.
52. Julie A. Sakowski et al., “Willingness to Recommend a Health Plan: Who Is Dissatisfied and What Don’t They Like?” *American Journal of Managed Care* 10, no. 6 (June 2004): 393–400.
53. Zuckerman et al., p. W4-374.
54. *Ibid.*, p. W4-379.
55. Julie A. Schoenman and Jacob J. Feldman, *2002 Survey of Physicians about the Medicare Program*, Project HOPE Center for Health Affairs, no. 03-1, March 2003, p. 43.
56. Oregon Health Services Commission, “Oregon Health Services Commission Report: Prioritized List of Benefit Packages for OHP Standard,” October 2001, p. 28. See also p. 29.
57. Davidoff, Garrett, and Yemane, p. 1.
58. “Medicaid’s Role for Women,” Kaiser Family Foundation Issue Brief no. 7213, November 2004.
59. Alina Salganicoff and J. Zoë Beckerman, “Women’s Health in the United States: Health Coverage and Access to Care,” Kaiser Family Foundation, May 2002, p. 40.
60. Robert Kaestner, Theodore Joyce, and Andrew Racine, “Does Publicly Provided Health Insurance Improve the Health of Low-Income Children in the United States?” NBER Working Paper no. 6887, January 1999, p. 1.
61. *Ibid.*, p. 2.
62. *Ibid.*, p. 21.
63. *Ibid.*, p. 22.
64. *Ibid.*, p. 25.
65. Jay Bhattacharya, Dana Goldman, and Neeraj Sood, “The Link between Public and Private Insurance and HIV-Related Mortality,” NBER Working Paper no. 9346, November 2002, p. i.
66. *Ibid.*, p. 14.
67. “Under Cash and Counseling in all three states, the beneficiary must first be enrolled in Medicaid, meet age and eligibility requirements, and require personal assistance services. Each participant receives a cash allowance, the amount of which is based on the level of professional assistance needed. Under the waiver, the program must be budget neutral, so the amount is generally equivalent to the value of services purchased by the state. While beneficiaries have considerable flexibility to hire, fire, and alter service providers, their allowance under Cash and Counseling must be spent on health care needs. A counselor or consultant reviews the list of services being purchased to ensure proper usage. The state also provides a fiscal intermediary to cut the checks, pay the appropriate taxes, and handle associated paperwork. The fiscal intermediary represents a final check on spending decisions of the beneficiary to weed out fraud and abuse.” James Frogue, “The Future of Medicaid: Consumer-Directed Care,” Heritage Foundation Backgrounder no. 1618, January 16, 2003.
68. Linda Giannarelli, Paul Johnson, Sandi Nelson, and Meghan Williamson, “TRIM3’s 2001 Baseline Simulation of Medicaid and SCHIP Eligibility and Enrollment: Methods and Results,” Urban Institute, TRIM3 Microsimulation Project Technical Paper, April 2005, p. 16, <http://aspe.hhs.gov/health/reports/05/medicaid-schip-simulation/report.pdf>. Many Medicaid-eligible individuals do not enroll until they need care, whereas others are able to obtain uncompensated care without ever enrolling.
69. Jim Frogue, “Medicaid’s Perverse Incentives,” *The State Factor* (American Legislative Exchange Council), July 2004, pp. 6–7.
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71. U.S. Census Bureau, “Historical Poverty Tables, Table 2: Poverty Status of People by Family Relationship, Race, and Hispanic Origin: 1959 to 2003,” August 26, 2004, <http://www.cen>

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73. George J. Borjas, "Welfare Reform, Labor Supply, and Health Insurance in the Immigrant Population," *Journal of Health Economics* 22, no. 6 (November 2003): 956–57. Emphasis added.

74. *Ibid.*, p. 942.

75. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2006 to 2015, January 2005*, p. 56; Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2006*, p. 24; and author's calculations.

76. See Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back American Health Care, and How to Free It* (Washington: Cato Institute, forthcoming), chaps. 5, 7.

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