Cato Handbook for Policymakers

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13. Medicaid and SCHIP

State legislators should

- deregulate health care and health insurance, and
- demand that the federal government grant them flexibility, not additional funds, to administer their Medicaid and SCHIP programs.

Congress should

- reform Medicare and the tax treatment of health insurance,
- deregulate health care and health insurance,
- eliminate any federal entitlement to Medicaid or SCHIP benefits,
- freeze each state's Medicaid and SCHIP funding at 2009 levels,
- give states total flexibility to use Medicaid and SCHIP funds to achieve a few broad goals, and
- eventually phase out all federal funding of Medicaid and SCHIP.

Americans want to help the needy obtain medical care. Our first obligation to the needy, however, is not to increase their numbers. Thus, the first step lawmakers should take to assist the needy is to eliminate subsidies and regulations that impede market competition. By making medical care of ever-increasing quality available to ever-increasing numbers of people, a free market would reduce the number of people needing assistance.

No matter how well a free market expands quality and access, however, there will always be seriously ill people who cannot afford medical care, or who could have purchased health insurance but chose not to do so. This chapter discusses how the federal and state governments might better address that problem.

The Samaritan's Dilemma

However we choose to help those in need, we confront what economists call ''the Samaritan's dilemma'': any effort to help the needy will induce others to take advantage of that assistance. Coined by Nobel Prize–winning economist James Buchanan, that term derives from the New Testament story of the Good Samaritan, who came to the aid of a traveler who had been beaten by thieves. Buchanan reasons that if the Samaritan decides to assist more unlucky travelers, travelers would likely take less care to avoid thieves and other hazards. Providing assistance to people can induce them to take less care of themselves.

For a modern manifestation of the Samaritan's dilemma, consider that in 1996 Congress reduced federal welfare benefits and cut millions of recipients from the welfare rolls. At the time, many predicted that cutting welfare would increase poverty. The opposite occurred. When people left the welfare rolls, poverty fell—often dramatically—for every racial category and age group, including children. In every year following 1996, the poverty rate has remained lower than at any point in the 17 years leading up to welfare reform. That fact suggests that the federal government had induced otherwise able-bodied people to become dependent on welfare.

The Samaritan's dilemma calls attention to the certainty that providing too little assistance will result in unnecessary suffering, but providing too much assistance will increase the burden of charity while it reduces society's ability to bear that burden. When assistance becomes more generous, more people will depend on it, and fewer will contribute to the economy and to charity, both public and private.

The Samaritan's dilemma is ubiquitous and unavoidable. It plagues both public and private charity.

To be effective, then, charitable efforts must attempt to distinguish between the truly needy and those who could care for themselves. No entity, public or private, can do that perfectly. Yet some approaches are more effective than others. Private charities, such as Habitat for Humanity, have the incentive and the ability to ensure that their resources assist only the truly needy. If it did not, Habitat could lose funding when donors learn their contributions are going to able-bodied people who don't need assistance.

Government, in contrast, has little ability or incentive to navigate carefully the Samaritan's dilemma. Politicians must craft broad eligibility rules for government welfare programs. Typically, these take the form of a legal entitlement to benefits for anyone who meets certain criteria. The bureaucrats who administer those programs must treat all qualifying indi-

viduals equally. If the bureaucracy identifies beneficiaries who technically meet those criteria, but nevertheless need no assistance, the bureaucrats have little ability or incentive to exclude them. In fact, they have the opposite incentive since their careers depend on a thriving welfare program. Even if the bureaucrats were to exclude those non-needy beneficiaries, the beneficiaries could sue the government for withholding benefits to which they are legally entitled. Unlike private charity, public charities rarely see their funding reduced for providing assistance to those who don't need it, because taxpayers don't have the choice to withdraw their ''contributions.'' Either they pay their taxes, or they go to jail. As a result, government charities, such as cash assistance, Medicaid, and the State Children's Health Insurance Program, tend to err on the side of providing too much assistance and subsidizing people who don't need it.

There are ways that government can make medical care and health insurance affordable for low-income Americans that do not involve a Samaritan's dilemma. Federal and state governments can reform Medicare (see Chapter 12) and the tax treatment of health care (see Chapter 14), as well as deregulate medicine (see Chapter 15) and health insurance (see Chapter 16).

Government can better navigate the Samaritan's dilemma, however, by reforming and reducing the size of Medicaid and the State Children's Health Insurance Program.

Medicaid

The federal government and state and territorial governments jointly administer Medicaid—or more precisely, the 56 separate Medicaid programs throughout the United States. Medicaid participation is ostensibly voluntary for states, if not for taxpayers. States that wish to participate (all states do) must provide a federally mandated set of health benefits to a federally mandated population of eligible individuals. In return, each state receives federal funds to administer its program. On average, 57 percent of Medicaid funding comes from the federal government and 43 percent comes from the states. States can make their Medicaid benefits more generous than the federal government requires and can also extend eligibility to more people than the federal government requires. For beneficiaries, Medicaid is an entitlement. So long as they meet the eligibility criteria, they can receive benefits.

According to the Kaiser Family Foundation, in 2005 Medicaid enrollment reached nearly 60 million individuals. Medicaid primarily serves

four low-income groups: mothers and their children, the disabled, the elderly, and those needing long-term care. The elderly and disabled comprised 24 percent of beneficiaries, but accounted for 70 percent of expenditures on benefits. Half the enrollees were children, while other adults comprised the remaining 26 percent of enrollees. Those two groups—children and nonelderly, nondisabled adults—comprised 76 percent of enrollees but accounted for 30 percent of expenditures on benefits.

The federal government's method for distributing Medicaid funds to states encourages fraud, creates perverse incentives for state officials, and encourages states to expand their programs to people who don't need assistance. The federal government provides Medicaid funds to each state in proportion to what the state itself spends. The more a state spends on its Medicaid program, the more it receives from the federal government. States receive at least $1 from the federal government for every dollar the state spends. Some states, however, receive as much as $3 for each dollar they put forward. Thus, states can double, triple, or even quadruple their money by spending more on Medicaid. Indeed, states that use fraudulent schemes, such as *pretending* to increase Medicaid spending in order to draw down federal matching funds, can increase their take even further. The federal Medicaid ''match'' is open-ended; Congress will match any amount a state puts forward.

The availability of matching federal funds creates perverse incentives for state officials to underfund other priorities. Spending $1 on police buys $1 of police protection, but spending $1 on Medicaid buys $2 or more of medical benefits. The federal match also makes lawmakers extremely reluctant to cut Medicaid spending. Cutting $1 of police protection causes $1 of political pain, but results in $1 of budget savings. Obtaining just $1 of budgetary savings through Medicaid cuts requires inflicting $2 to $4 worth of political pain.

Those perverse incentives combine to encourage states to expand their programs to millions of non-needy recipients. For example:

- According to the Urban Institute, about one-fifth of adults and children who are *eligible* for Medicaid nonetheless obtain private coverage. The fact that some 20 percent of those who fall within states' Medicaid eligibility criteria obtain private coverage suggests that many who are enrolled could obtain private coverage as well.
- Middle-class families frequently use Medicaid to pay for nursing-home and other long-term care expenses of their elderly members. A cottage industry of estate planners has emerged to help such

individuals artificially impoverish themselves to become eligible for Medicaid. Many elderly Medicaid enrollees could have purchased private long-term care insurance. Economists Jeffrey Brown of the University of Illinois at Urbana-Champaign and Amy Finkelstein of MIT estimate that Medicaid's long-term care benefits discourage 66 to 90 percent of seniors from purchasing such insurance on the private market.

- The 1996 welfare reform law also cut eligibility to Medicaid for noncitizen immigrants. Harvard economist George Borjas found that, again contrary to expectations, health insurance coverage among noncitizen immigrants *increased* after their eligibility for Medicaid was reduced—an effect that could not be explained by the robust economy of the 1990s. Borjas argues that affected immigrants increased their work effort and found jobs with health benefits.
- Economists Jonathan Gruber of MIT and Kosali Simon of Cornell University estimate that when Medicaid expands eligibility to new groups, ''the number of privately insured falls by about 60 percent as much as the number of publicly insured rises.'' That suggests that many people substitute Medicaid coverage for private coverage.

Medicaid's poor navigation of the Samaritan's dilemma has even permeated popular culture. The 2004 Oscar-winning film *Million Dollar Baby* showcased two forms of Medicaid abuse: One of the film's characters declined the gift of a new house so she could remain eligible for Medicaid (rather than sell the house and purchase her medication herself). Later, the family of a wealthy invalid encouraged the invalid to transfer her assets to the family so that taxpayers (through Medicaid) would pay the wealthy invalid's medical expenses.

Indeed, the more a state expands its Medicaid program, the more difficult it becomes for everyone to afford private insurance. Economists Mark Duggan of the University of Maryland and Fiona Scott Morton of Yale University find Medicaid's drug-pricing controls effectively increase by 13 percent the prices that private purchasers pay for prescription drugs. If grandma's medications cost her $1,000 per year, some $117 of that is a hidden tax attributable to Medicaid.

The State Children's Health Insurance Program

What is true of Medicaid is true of the State Children's Health Insurance Program. Congress created SCHIP in 1997 to expand health insurance

coverage among children in families that earned too much to be eligible for Medicaid but too little to afford private health insurance.

The federal government funds state SCHIP programs much as it funds Medicaid, but with two main differences. First, states receive a larger federal match under SCHIP than under Medicaid. Overall, the federal government funds 69 percent of the cost of state SCHIP programs, whereas states forward only 31 percent. Each state can *at least* triple its money by spending on SCHIP. Some states can ''pull down'' $4 or $5 from the federal government—really, from taxpayers in other states—for each $1 they spend on SCHIP. Second, the federal government limits the overall amount it will contribute to each state's SCHIP program, though that cap is not as binding as it may appear. States such as Georgia sometimes spend all their federal SCHIP funds before the end of the fiscal year, and then petition the federal government for additional funds. Another way to describe those states' behavior is to say that they demand more money and dare Congress to throw sick children off the SCHIP rolls. Congress has repeatedly bailed out such states, effectively rewarding them for committing to spend more federal dollars than they were allowed.

As a result of these perverse incentives, states such as New Jersey have expanded SCHIP eligibility to children in families of four earning as much as $72,000 per year. New York proposed expanding the program to families of four earning $82,000 per year. The Bush administration subsequently refused to provide federal SCHIP funds for families earning over 250 percent of the federal poverty level (about $51,000 for a family of four) unless a state enrolls in Medicaid and SCHIP 95 percent of eligible individuals below that threshold. (The future of that directive is uncertain.) Compared with Medicaid, SCHIP targets families higher up the income scale, who are therefore more likely to have private health insurance. As a result, SCHIP leads to even greater ''crowd-out'' of private insurance than Medicaid. The Congressional Budget Office reports that by 2006, some 670,000 *adults* had enrolled in the program.

Federal and state politicians devote significant resources to these programs even though expanding coverage may not be the best way to improve the health of targeted populations. Although Medicaid and SCHIP probably do improve health outcomes, economists have found no evidence that these programs produce the greatest possible health improvements for the money spent. Economists Helen Levy and David Meltzer write:

> It is clear that expanding health insurance is not the only way to improve health. . . . Policies could also be aimed at factors that may fundamentally

> contribute to poor health, such as poverty and low levels of education. There is no evidence at this time that money aimed at improving health would be better spent on expanding insurance coverage than on any of these other possibilities.

Major reform of Medicaid and SCHIP is long overdue.

Congress Should Reform Medicaid and SCHIP as It Reformed Welfare

It makes little sense for taxpayers to send money to Washington, so those funds can be sent back to their state capitol with strings and perverse incentives attached. Congress should devolve control over Medicaid and SCHIP to the states. The states can then decide whether and how to maintain their own programs, and could learn from the successes and failures of one another's experiments.

In 1996, Congress eliminated the federal entitlement to a welfare check; placed a five-year limit on cash assistance; and froze federal spending on such assistance, which was then distributed to the states in the form of block grants with fewer federal restrictions. The results were unquestionably positive. Welfare rolls were cut in half, and poverty reached the lowest point in a generation.

The federal government should emulate this success by eliminating federal entitlements to Medicaid and SCHIP benefits, freezing federal Medicaid and SCHIP spending at current levels, and distributing those funds to the states as unrestricted block grants. That would eliminate the perverse incentives that favor Medicaid and SCHIP spending over other state priorities, and that encourage states to defraud federal taxpayers. According to Congressional Budget Office projections, freezing Medicaid and SCHIP spending at 2009 levels would produce $979 billion in savings by 2018. That would significantly reduce or even eliminate future federal deficits. In time, the federal government should give the states full responsibility for Medicaid by eliminating federal Medicaid spending while concomitantly cutting federal taxes.

States should hasten these reforms by pressuring the federal government for maximum flexibility in administering their Medicaid programs. With unrestricted Medicaid block grants, states that wanted to spend more on their Medicaid programs would be free to raise taxes to do so, and vice versa.

Suggested Readings

Borjas, George J. ''Welfare Reform, Labor Supply, and Health Insurance in the Immigrant Population.'' *Journal of Health Economics* 22 (November 2003).

Cannon, Michael F. ''Medicaid's Unseen Costs.'' Cato Institute Policy Analysis no. 548, August 18, 2005.

_____. ''Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs.'' Cato Institute Briefing Paper no. 99, September 13, 2007.

Cannon, Michael F., and Michael D. Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It*. Washington: Cato Institute, 2007.

Moses, Stephen. ''Aging America's Achilles' Heel: Medicaid Long-Term Care.'' Cato Institute Policy Analysis no. 549, September 1, 2005.

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