Approved: March 7, 2007
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 P.M. on February 13, 2007 in Room 526-S of the Capitol.

All members were present.

Committee staff present:
Norman Furse, Revisor's Office
Melissa Calderwood, Legislative Research
Mary Galligan, Legislative Research
Patti Magathan, Committee Assistant

Conferees appearing before the committee:
Michael Tanner, Director Health & Welfare Studies, CATO Institute

Others Attending:
See Attached List.

The Committee heard a presentation on Health Care Reform from Michael Tanner, Director, Health and Welfare Studies of the CATO Institute, Washington, DC. In developing health policy it is vital to keep in mind one pertinent fact: for all its problems, the United States offers the highest quality health care in the world.

It is important, therefore, that any reform of the health care system, either nationally or here in Kansas, not destroy those things that make our health care system so effective–individual choice and free markets. You should avoid the temptation to increase government regulation and control over the state's health care system. All national health care systems ration care.

There are clearly problems with the United States and Kansas health care systems that need to be addressed. There are too many Kansas who lack health insurance, which presents a problem for the state. When an individual without health insurance becomes sick or injured, he or she still receives medical treatment. Such treatment is not free, with the cost simply shifted to those with insurance or more often to taxpayers.

States are generally exploring three possible and equally problematic avenues toward achieving universal coverage.

First is to have the government pay for health care, by leaving the basic system intact while expanding government subsidies to low-income individuals and other groups by increasing eligibility for entitlement programs or through Medicaid reforms.

A second approach is to impose a mandate on employers. This involves requiring all employers over a certain size to either provide their workers with health insurance or pay taxes to a government program that will insure those workers.

Mandating individuals to have insurance is a third approach but would probably not work. This is a significant infringement on individual liberty and decision making, not to mention practical difficulties of enforcement and compliance.

A combination of employer/employee mandated insurance being called the "connector" is an approach recently developed in Massachusetts. A connector would allow individuals and workers in small companies to take advantage of the economies of scale in terms or administration and risk pooling. The Connector would not actually be an insurer but would function as a clearinghouse to match customers with providers and products.

It is sadly true that the keys to health care reform lie in federal, not state, legislation. Be extremely careful to make sure that impatience does not push Kansas into taking steps that will ultimately make the problem

far worse. (Attachments 1, 2 & 3)

Chair Landwehr announced that we wouldn't work **HB2174** today due to some unanswered questions.

Chair Landwehr opened the floor to work **HB2009** - Vaccinations by pharmacists to persons of any age., and **HB2097** - Administering of vaccines by pharmacists, pharmacy students and interns to persons age five and older and announced that we would work both bills together.

Representative Hill explained that **HB2009** and **HB2097** were very similar. **HB2009** eliminated the existing age requirement from statute, which received substantial objection. For that reason he would recommend leaving the age requirement as it is in current statute and taking no action on this bill.

Representative Hill also noted that **HB2097** added a provision for students who have been trained and had also attempted to lower the age requirement to 5 years or older. The age reduction had met with substantial objection. For that reason he would recommend leaving the age requirement as it is in current statute and motioned to amend **HB2097** to change five years to 18 years. Motion carried. Representative Hill then made a motion, seconded by Representative Morrison, to pass **HB2097** favorably as amended. Motion carried. Representative Hill will carry the bill.

Chair Landwehr then announced that we would work **HB2098** - Defining certain terms relating to human cloning.

Representative Mast moved that this bill be recommended favorable for passage. Motion seconded by Representative Kiegerl.

Representative Flaharty made a motion to table **HB2098**, which was seconded by Representative Storm. Voice vote was unclear so division was called. Vote was Aye 9, Nay 10. Motion failed.

Back on the motion to pass **HB2098** favorably, vote was Aye 11 and Nay 9. Motion passed. Following are Representatives who asked that votes be recorded as opposing the bill. They were Representatives Flaharty, Storm, Hill, Ward, Garcia, Trimmer, Neighbor, Tietze, and Holland. Representative Mast will carry the bill.

Meeting was adjourned. Next meeting will be Feb. 14 at 1:30.

HOUSE HEALTH AND HUMAN SERVICES
COMMITTEE GUEST LIST

DATE: February 13, 2007

NAME	REPRESENTING
Gary Robbins	Ks Optometric Assn
Renae Ann Rowen	KAHP
Martyn Turner MD	DOD / KAFP
Jerry SLAUGHTER	KAHS
Chip Wheelen	Ass'n of Osteopathic Med.
John Peterson	Ks Coalition for Lifesaving Cures
Ron Secker	Hein Law Firm
Carolyn Middendorf	Ks St Nurses Assn
Jeanne Gawdun	KFL
Sandy Braden	Cure Council of ICC
MATT Reaves	Rep Don Hill
BEATRICE SWOOPES	KS CATHOLIC CONFERENCE
Duane Simpson	Biotechnology Industry Organization

TESTIMONY OF

MICHAEL TANNER

DIRECTOR, HEALTH & WELFARE STUDIES

CATO INSTITUTE, WASHINGTON, DC

February 13, 2007

Mr. Chairman:

My name is Michael Tanner and I appreciate the invitation to appear today and the opportunity to share my perspective on the vital issue of reforming health care and what Kansas can and cannot do to help resolve this issue.

For the past 13 years I have been director of health & welfare studies for the Cato Institute in Washington, DC. Before that I served as legislative director for the Georgia Public Policy Foundation and as legislative director for health & welfare with the American Legislative Exchange Council. In all, I have spent more than 20 years studying the American health care system and am the author of five books on health care reform, most recently *Healthy Competition: What's Holding Back American Health Care and How to Free It.*

During my time studying this issue, I have concluded that, in developing health policy it is vital to keep in mind one pertinent fact: for all its problems, the United States offers the highest quality health care in the world. Most of the world's top doctors, hospitals, and research facilities are located in the United States. The University of Kansas Hospital, for example, is considered a center of

excellence in cancer treatment. Eighteen of the last 25 winners of the Nobel Prize in Medicine either are U.S. citizens or work in this country.[1] U.S. companies have developed half of all the major new medicines introduced worldwide over the past 20 years.[2] In fact, Americans played a key role in 80 percent of the most important medical advances of the past 30 years.[3] Nearly every type of advanced medical technology or procedure is more available in the United States than in any other country.[4] By almost any measure, if you are diagnosed with a serious illness, the United States is the place you want to be. That is why tens of thousands of patients from around the world come to this country every year for treatment.

Of course, I'm aware that, as critics of American health care often point out, other countries have higher life expectancies and lower infant mortality rates, but those two indicators are not a good way to measure the quality of a nation's health care system. In the United States, very low-birth-weight infants have a much greater chance of being brought to term with the latest medical technologies. Some of those low-birth-weight babies die soon after birth, which boosts our infant mortality rate, but in many other Western countries, those high-risk, low-birth-weight infants are not included when infant mortality is calculated. And life expectancies are affected by exogenous factors like violent crime, poverty, obesity, tobacco and drug use, and other issues unrelated to health

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[1] "Nobel Prize in Physiology or Medicine Winners 2006–1901," The Nobel Prize Internet Archive, http://almaz.com/nobel/medicine/medicine.html.
[2] Pharmaceutical Manufacturers Association, "Facts about the U.S. Pharmaceutical Industry," 2002.
[3] *Economic Report of the President* (Washington: Government Printing Office, 2004), p. 192
[4] Gerard Anderson et al., "It's the Prices Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (May/June 2003): 99.

care. In contrast, when you compare the outcome for specific diseases like cancer or heart disease, the United States clearly outperforms the rest of the world.[5]

Take prostate cancer, for example. Even though American men are more likely to be diagnosed with prostate cancer than their counterparts in other countries, we are less likely to die from the disease. Less than one out of five American men with prostate cancer will die from it, but 57 percent of British men and nearly half of French and German men will. Even in Canada, a quarter of men diagnosed with prostate cancer, die from the disease.

Similar results can be found for other forms of cancer. For instance, just 30 percent of U.S. citizens diagnosed with colon cancer die from it, compared to fully 74 percent in Britain, 62 percent in New Zealand, 58 percent in France, 57 percent in Germany, 53 percent in Australia, and 36 percent in Canada. Similarly, less than 25 percent of U.S. women die from breast cancer, but 46 percent of British women, 35 percent of French women, 31 percent of German women, 28 percent of Canadian women, 28 percent of Australian women, and 46 percent of women from New Zealand die from it.[6]

It is important, therefore, that any reform of the health care system, either nationally or here in Kansas, not destroy those things that make our health care system so effective—individual choice and free markets. In particular, you

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[5] Miranda Mugford, "A Comparison of Reported Differences in Definitions of Vital Events and Statistics," *World Health Statistics Quarterly* 36 (1983), cited in Nicholas Eberstadt, *The Tyrany of Numbers: Measurements & Misrule* (Washington: American Enterprise Institute press, 1995), p. 50.

[6] Varduhi Petrosyan, and Peter Hussey, *Multinational Comparisons of Health Systems Data, 2002* (New York: The Commonwealth Fund, 2002), pp. 55–62; Gerard Anderson and Peter Hussey, *Multinational Comparisons of Health Data Systems Data, 2000* (New York: The Commonwealth Fund, 2000), pp. 17–18; Gerard Anderson and Bianca Frogner, *Multinational Comparisons of Health Data Systems Data, 2005* (New York: The Commonwealth Fund, 2006).

should avoid the temptation to increase government regulation and control over the state's health care system.

After all, the one common characteristic of all national health care systems is that they ration care. Sometimes they ration it explicitly, denying certain types of treatment altogether. More often, they ration more indirectly, imposing global budgets or other cost constraints that limit the availability of high-tech medical equipment or imposes long waits on patients seeking treatment. For example, one million Britons are waiting for admission to National Health Service hospitals at any given time, and shortages force the NHS to cancel as many as 100,000 operations each year. Roughly 90,000 New Zealanders are facing similar waits. In Sweden, the wait for heart surgery can be as long as 25 weeks, while the average wait for hip replacement surgery is more than a year. And, in Canada more than 800,000 patients are currently on waiting lists for medical procedures.[7]

Still, there are clearly problems with the US and Kansas health care systems that need to be addressed. For example, too many Kansans lack health insurance. Some 300,000 Kansas citizens were uninsured for at least part of 2005, roughly 10.9 percent of the state's population.[8] While this is considerably less than the national uninsurance rate, it nonetheless represents a problem for the state for several reasons.

First, while we should be careful about equating insurance coverage with access to health care and access to better health, we should be concerned about whether uninsured Kansans are receiving the health care they need. The

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[7] See Michael Cannon and Michael Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington: Cato Institute: 2005), pp. 36–37.
[8] AARP, State Health Profiles 2006.

academic evidence is quite mixed about whether being uninsured results in poorer health outcomes. However, there appears to be some evidence that those without health insurance may delay receiving treatment or receive less preventive care. Certainly, you have all encountered anecdotal evidence of hardships encountered by the uninsured. These hardships should not be discounted.

In addition, we should understand that when an individual without health insurance becomes sick or injured, he or she still receives medical treatment. In fact hospitals have a legal requirement to provide care regardless of ability to pay. Physicians do not face the same legal requirement, but few are willing to deny treatment because a patient lacks insurance. However, such treatment is not free. The cost is simply shifted to others, those with insurance, or more often, taxpayers. Thus, to a large degree individuals without health insurance are "free-riding" on the rest of us. We should not, however, overstate these costs. Nationally, the cost of uncompensated care amounts to 3-5 percent of total health care spending.[9] This is a problem, to be sure, but not a crisis.

We should also be aware that those most likely to go without health insurance are the young and relatively healthy. For example, although 18 to 24 year olds are only 10 percent of the U.S. population, they are 21 percent of the long-term uninsured.[10] For these young, healthy individuals, going without health insurance is often a logical decision. However, this becomes a form of adverse

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[9] Greg Scandlen, "The Pitfalls of Mandating Health Insurance," *Council for Affordable Health Insurance's Issues & Answers,* no. 135 (April 2006).

[10] Rob Stewart and Jeffrey Rhoades, "The Long-Term Uninsured," Research Note, U.S. Census Bureau, http://aspe.hhs.gov/health/long-term-uninsured04/report.pdf.

selection. Removing the young and healthy from the insurance pool means that those remaining in the pool will be older and sicker. This results in higher insurance premiums for those who are insured, at least to the degree that there are cross subsidies in existing pools. (If everyone's rates are actuarially fair, then young people's explicit or implicit premiums do not result in lower or higher premiums for anyone else.)

Generally, states are exploring three possible—and equally problematic--avenues toward achieving universal coverage.

The first is to have the government pay for health care. At its most radical, this means embracing a single-payer health care system such as those in Canada or Europe. However, as I mentioned at the beginning of my remarks, the one common characteristic of such government-run health care systems is that they ration care. Indeed, recently the Canadian Supreme Court struck down a portion of that country's national health care system, noting that, "Access to a waiting list is not access to health care…there is unchallenged evidence that in some serious cases people die as a result of waiting lists for public health care."[11]

Less radical proposals would leave the basic health care system intact while expanding government subsidies to low-income individuals and other groups, by increasing eligibility for Medicaid, SCHIP, and other programs. Expansion of these subsidies seem particularly popular with state legislatures since it enables states to maximize their receipt of federal funds, shifting at least a portion of the cost to out-of-state taxpayers.

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[11] *Chaoulli v. Quebec* (Attorney General), 2005 SCC 35, p. 4.

However, while some level of subsidy may indeed be necessary for the poorest Kansans, the state should proceed cautiously in this regard. Subsidies are liable to squeeze out unsubsidized coverage, encouraging businesses to cease offering employer provided plans, shifting the cost of insurance to taxpayers. This crowding-out phenomenon has been readily apparent with both the traditional Medicaid and SCHIP programs. A Robert Wood Johnson Foundation survey of 22 studies of the relationship between government insurance programs and private coverage concluded that substitution of government for private coverage "seems inevitable."[12] Other studies have shown that when government programs are cut back, private coverage increases.[13]

Even Medicaid reforms that are otherwise appealing should be approached cautiously. For example, vouchers and health savings accounts may actually make Medicaid compared more attractive compared to pri9vate insurance, increasing the likelihood that employers and individuals will abandon traditional insurance for the program, especially if Medicaid eligibility is extended up the income range as part of the reform.

It should be remembered that health care subsidies to the low-income are essentially a form of welfare. In fact, Medicaid provides average benefits twice as valuable as those available under federal cash assistance programs. Unsurprisingly, studies have found that Medicaid increases dependence and

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[12] Getsur Davidson et al., "Public Program Crowd-Out of Private Coverage: What Are The Issues?" Robert Woods Johnson Foundation Research Synthesis Report no. 5, June 2004.
[13] George Borjas, "Welfare Reform, Labor Supply, and Health Insurance in the Immigrant Population," *Journal of Health Economics.*22 (2003): 956-957.

discourages self-reliance in the same way that other welfare programs do.[14] Therefore, in reforming Medicaid, states should apply many of the lessons of welfare reform, imposing eligibility restrictions, work requirements, and other welfare-reform-style barriers to discourage people from becoming dependent on the program.

If government is not to pay for universal health insurance, a second approach considered by many states is to impose a mandate on employers. Under most designs, such an approach would require all employers over a certain size to either provide their workers with health insurance or pay taxes to a government program that will insure those workers. Attempts to impose such employer mandates have generally run afoul of ERISSA and been struck down by the courts. But that has not prevented states from continuing to try.

The drawbacks of an employer mandate are obvious. The amount of compensation each worker receives is a function of his or her productivity. The employer is indifferent to the makeup of that compensation between wages, taxes, insurance premiums, or other costs associated with that worker's employment. Mandating an increase in a worker's compensation (through the provision of health insurance) increases the worker's operating costs without increasing the worker's productivity. Employers must therefore find ways to offset the added costs imposed by the mandate. Options include raising prices (which is unlikely in a competitive market), lowering wages, reducing wage increases, reducing other health costs (such as drug coverage or retiree health

[14] See, for example, Aaron Yelowitz, "Evaluating the Effects of Medicaid on Welfare and Work: Evidence from the Past Decade," Employment Policies Institute, December 2000.

benefits), reducing other benefits (such as pensions), instituting layoffs, replacing workers with automation, reducing hiring, hiring ineligible workers including undocumented aliens, out-sourcing work overseas, or even moving their operations out of state or out of the country. In almost all these cases, the net result will be to hurt the workers that the mandate was designed to help.

If an employer mandate will not work, what about a mandate on individuals? Recently, there has been a great deal of interest in such an approach, a legal requirement that every resident of a state obtain adequate private health insurance coverage. Those who don't receive such coverage through their employer or some other group would be required to purchase individual coverage. Failure to comply would result in some form of penalty, financial or otherwise. Such a mandate was a key component of last year's Massachusetts health reform that has received widespread national attention.

Because, unlike single-payer or employer mandates, an individual mandate has received substantial support from organizations and individuals otherwise disposed towards a free market approach to health care reform, I would like to take a little extra time to explain why I believe that this is a very bad idea.

It is import to recognize that such a mandate would represent a significant infringement on individual liberty and decision making. As the Congressional Budget Office has noted, "The government has never required people to buy any good or service as a condition of lawful residence in the United States."[15] And

[15] Robert Hartman and Paul van de Water, "The Budgetary Treatment of an Individual Mandate to Buy Health Insurance," Congressional Budget Office Memorandum, August 1994.

prior to Massachusetts enactment of an individual mandate last year, neither had any state. Some have compared an individual health insurance mandate to the current state mandate for automobile insurance. This is an imperfect analogy, however. First, it has long been recognized that driving is a privilege, subject to all manner of regulatory requirements. If one does not like the regulations, including an insurance mandate, one can choose not to drive. A health insurance mandate would not generally give people such a choice. Second, the reason states mandate auto insurance is for the protection of *others* rather than oneself. Most states do not mandate you carry insurance for your own injury or repair costs

Beyond questions of individual liberty, however, there are serious practical questions about an individual mandate.

For example, to enforce a health insurance mandate, some agency of the Kansas government would need some way to determine whether Kansans are insured or not and to penalize those who have not complied with the mandate. But government's record of enforcing insurance mandates has not been an overwhelming success. For example, 47 states have laws mandating that drivers purchase automobile liability insurance. Yet, roughly 14.5 percent of drivers in those states are uninsured.[16] Here in Kansas roughly 10 percent of drivers don't have the required coverage, barely better than the rate of Kansans without health insurance. Clearly an automobile insurance mandate, with fines as high as

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[16] Greg Kelly, "Can Government Force People to Buy Insurance?" Issues & Answers No. 123, Council for Affordable Health Insurance, March 2004, citing data from the Insurance Research Council. http://www.cahi.org/cahi_contents/resources/pdf/n123GovernmentMandate.pdf.

$1,000 has failed to force Kansans to buy insurance. There is no reason to believe that a health insurance mandate will be more successful.

The most common solution is to require that Kansans submit proof of insurance when they file their state income taxes. But thousands of Kansans are either not currently required to file tax returns or fail to file despite being required to. Some of these nonfilers are elderly, homeless, the mentally ill, and illegal aliens. Others will have changed their address, perhaps multiple times. Does anyone truly believe that it will be possible to track down every last person in the state and determine whether or not they have health insurance?

Moreover, only about 30 percent of uninsured Americans have been uninsured for a full year. In fact nearly 45 percent will regain insurance within four months.[17] Therefore many Kansans who lack health insurance at some point throughout the year, will in fact be insured at the time they file their taxes. Presumably, the "proof of insurance" could include of the length of time that the person was insured, but that would raise the complexity of compliance procedures considerably. It would also increase the incentive to lie.

If the government were able to determine that someone has not purchased health insurance, what penalty would apply? Ideas have been suggested ranging from loss of drivers licenses to direct fines to some sort of tax penalty. Again, as a practical measure, all these approaches are problematic in dealing with low-income individuals, people who don't file income taxes, transients, and others who are likely to be uninsured. It is unrealistic, therefore,

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[17] Lyle Nelson, "How Many People Lack Health Insurance and for How Long?" Congressional Budget Office, May 12, 2003.

to believe that an individual mandate likely to achieve anything close to universal coverage or significantly reduce health care costs.

On the other hand, the mandate crosses an important line, accepting the principle that it is the government's responsibility to assure that every American has health insurance. In doing so, it opens the door to further widespread regulation of the health care industry and political interference in personal health care decisions. The result will be a slow but steady spiral downward toward a government-run health care system.

Whatever the initial minimum benefits package consists of, special interests representing various health care providers and disease constituencies can certainly be expected to lobby for the inclusion of additional services or coverage under any mandated benefits package.

Public choice dynamics are such that providers (who would make money from the increased demand for their services) and disease constituencies (whose members naturally have an urgent desire for coverage of their illness or condition) will always have a strong incentive to lobby lawmakers for inclusion under any minimum benefits package. The public at large will likely be unaware of the debate or see resisting the small premium increase caused by any particular additional benefit as unworthy of a similar effort. It is a simple case of concentrated benefits and diffuse costs.

As more benefits were added, the cost of the mandate would increase. That will place legislators in a very difficult position. If they increase subsidies to keep pace with the rising cost of the mandate, the cost of the program will

explode. On the other hand, if they hold subsidies steady, the increased cost will be borne by consumers, who would have no choice but to continue purchasing the ever more expensive insurance. Since the consumers would have little or no leverage over insurers (they can no longer refuse to buy their products), they can eventually be expected to turn to the government for relief.

Attempts to scale back benefits would certainly meet political opposition from powerful constituencies and complaints about "cuts." The only other alternative would be for the government to intervene directly by capping premiums. Insurers unable to charge more for an increasingly expensive product can be expected to trim costs by cutting back on their reimbursement rates to hospitals and physicians. The result will ultimately be rationing, the lack of available health care goods and services.

An individual mandate, therefore, should not be seen in a vacuum. It is more akin to the first in a series of dominoes. "If you want to go down the road of an individual mandate, it's necessary to reform the entire health insurance system to make sure healthy people can get affordable coverage and sick people are not priced out of the market," says Gail Shearer of Consumers Union.[18] By distorting the health care marketplace, an individual mandate sets in place a cascading series of additional mandates and regulations resulting, ultimately, in a government-run health care system.

A second problem with Kansas' health care system lies in the dysfunction of its individual and small group insurance markets. Both of these markets are

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[18] Quoted in Julie Appleby, "Mass. Gov. Romney's Health Care Plan Says Everyone Pays," *USA Today*, July 4, 2005.

highly regulated in Kansas, as in most other states, making them inefficient and leading to higher costs. Other states have attempted to solve this problem by combining the two markets and establishing a single regulatory system with the expectation that individual and small group insurance would become more available and affordable. This is the approach that led to the development of "The Connector" in Massachusetts. Several other states are also considering the "connector" model, and I understand Kansas to also be looking at this approach. However, I believe it would be a tremendous mistake for your state to go down this road.

As generally conceived, a Connector would allow individuals and workers in small companies to take advantage of the economies of scale, both in terms of administration and risk pooling, which are currently enjoyed by large employers. Multiple employers would be able to pay into the Connector on behalf of a single employee. And, most importantly, a Connector would allow workers to use pre-tax dollars to purchase individual insurance. This would make insurance personal and portable, rather than tying it to an employer, all very desirable things.

Again, as conceived, a Connector would not actually be an insurer. Insurance would still be provided by the private sector. Rather, a Connector would function as a clearinghouse, a sort of wholesaler or middleman, matching customers with providers and products. Most promisingly, when offered as an option under Section 125 plans, it provides a way around the federal tax

preference for employer-provided insurance. If that is all it did, the Connector would be modestly useful tool.

However, in practice, at least as demonstrated in Massachusetts, the Connector can quickly devolve into a regulatory body. For example, in Massachusetts, the Connector has wide-ranging authority to determine what insurance products it will offer. The connector is authorized to offer a "connector seal of approval" to products that provide "high quality and good value." The connector itself is left to define what constitutes high quality and a good value, but significantly, that phrase frequently appears in legislation as justification for mandated benefits. The connector may choose to sell products that do not receive its seal of approval, but they are not required to do so. In addition, the maximum deductible allowed is $2,700 for an individual and $5,450 for a family. While this conforms to current federal law, it locks in the status quo at a time when attempts are being made to change federal Health Savings Account restrictions. Moreover, individuals choosing a high-deductible policy *must* combine it with a Health Savings Account. And policies must be community-rating and meet other restrictions designed to limit the ability of insurers to segment the market according to risk.[19]

As a result of these Connector-imposed restrictions the price of policies it will offer has risen dramatically even before the program becomes operational. Originally estimated by Governor Romney to cost around $250 per month, the cheapest available policy is now expected to cost more than $380 per month.

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[19] Chapter 58 of the Acts of 2006, sections 101 and 76.

No actual prohibition exists on selling small group or individual insurance outside the Connector. However, because the subsidies and tax advantages are available only within the connector, and because of its competitive advantage in terms of pooling costs and risk, the connector will eventually squeeze out any outside market. In the end, the connector can be expected to become a monopsony purchaser of health insurance.

In practice, the Connector appears to be a form of managed competition. Managed competition, which was the centerpiece of the failed 1993 Clinton health plan, is a scheme under which insurance is provided by the private sector but within an artificial government designed and controlled marketplace. Managed competition is meant to spur competition between health plans, yet competition takes place on a very limited basis. Some limited price competition is likely to occur, but because plans cannot reduce costs by managing risks or through benefit design, even that will be marginal. This situation is particularly problematic since an inability to price according to risk generally causes insurers to retreat toward the mean. This step results in an overprovision of services to the healthy and an underprovision to the sick.

Managed competition is an attempt to be a little bit pregnant on the question of markets versus government control. Or, as University of Chicago Law Professor Richard Epstein says, managed competition is "an oxymoron. One can either have managed health care or competition in health care services. It is not possible to have both simultaneously."[20]

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[20] Richard Epstein, "Unmanageable care," *Reason*, May 1993.

The dangers inherent with creating a potential new regulatory body such as a Connector would appear to substantially outweigh any advantages, particularly given other options for reforming the individual and small group insurance markets that I will discuss shortly. However, at the very least, should you decide to create a Connector, it should not only be prohibited from regulating insurance, it should be specifically required to offer any health insurance product otherwise approved for sale in the state.

What, then, can Kansas do to improve its health care system? The unfortunate reality is that the state's options are limited because the real villains and solutions to America's health care ills lie in Washington, and specifically with the federal tax code, beyond the reach of state lawmakers. However, there are some important steps that this state can take that will reduce the cost of health care and increase the number of people who are insured, while preserving—and even improving—the quality of the current system.

First, Kansas should do what it can to reduce the cost of health insurance. After all, the number one reason that people give for not purchasing insurance is that they cannot afford it.[21] This is particularly true for young and healthy individuals that precisely the people who we should be encouraging to enter the insurance market before they become older and sicker. Yet, current state regulations drive up the cost of health insurance and make it a reasonably logical decision for these young healthy individuals to remain uninsured.

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[21] "The Uninsured: A Primer, Key Facts About Americans Without Health Insurance," Kaiser Family Foundation, December 2003

For example, Kansas currently has some 37 mandated benefits, putting Kansas in the worst half of states for the number of mandates. These include mandates that all insurance policies sold in the state include coverage for Alzheimer's disease, bone mass measurement, cancer pain medications, dental anesthesia, diabetes self-management, diabetic supplies, drug abuse treatment, mammograms, mastectomies and extended mastectomy stays, mental health—including a requirement for mental health parity, off-label drug use, prostate screening, well-child care, chiropractors, dentists, nurse anesthesiologists, nurse practitioners, optometrists, oral surgeons, osteopaths, pain management specialists, psychologists, pharmacists, physical therapists, physicians assistants, podiatrists, and social workers.[22]

These mandates add significantly to the cost of insurance. The requirement for mental health parity alone adds as much as 10 percent to the cost of an insurance policy. Many of the other mandates add 1-3 percent each to insurance costs.[23] Clearly, people should be able to purchase coverage for such conditions and providers if they desire it. But just as clearly, those who wish to purchase a less inclusive but also less expensive policy should be able to do so. Repealing such mandates would be one of the most effective steps that Kansas could take to reduce the cost of health insurance and thereby increase the number of people with insurance.

Of course repealing such mandates will encounter fierce resistance from special interests and may prove politically difficult. There is therefore a

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[22] Victoria Craig Bunce, JP Wieske, and Vlasta Prikazky, "Health Insurance Mandates in the States, 2006," Council for Affordable Health Insurance, March 2006.
[23] Ibid.

potentially easier step that Kansas could take to achieve similar, indeed possibly more comprehensive, results. The state could amend its insurance laws to allow the sale of any health insurance plan approved for sale by ***any*** state.

Currently health insurance purchasers are essentially stuck with the regulatory regime of the state in which they reside. Kansas businesses and individuals are held hostage by Kansas insurance regulation. But if free to purchase health insurance regulated by states other than their own, customers could avoid regulations that added unwanted costs. They could, in effect, "purchase" another state's set of regulations by purchasing insurance from an insurer chartered in that state. If Kansans do not wish to purchase all 37 types of coverage mandates that your state requires, they could purchase insurance from, say, Idaho, where there are only 13, or any state whose laws are more closely aligned with their own preferences.

Not only would such a simple change to your state's insurance laws benefit consumers, reduce costs, and increase the number of people with insurance, but the same competitive process that drives producers to improve quality and reduce costs in other products could help produce higher quality regulations. Kansas would have to compete for the best regulatory environment in the same way it currently competes with other states for a better tax environment.

Secondly, the state should institute a thorough review of how it can reduce the cost of providing health care. In particular it should look at such issues as

expanding the scope of practice for nonphysician professionals, and removing barriers to hospital competition.

Third, the state should remove roadblocks to association health plans and other mechanisms for allowing small businesses to band together for the purposes of insurance pooling. The plans currently offered by the Wichita Independent Business Association, the Topeka Independent Business association, and the Kansas restaurant and Hospitality Association offer models for what such plans might look like.

And fourth, the state should continue to do all it can to expand the use of consumer-oriented health plans such as Health Savings Account. Here Kansas should be commended as a leader in removing barriers to HSAs and encouraging their use by state employees and others. I encourage you to continue those efforts and to remain vigilant against proposals that would restrict or limit such plans.

I regret that I have not been able to come here and offer a silver bullet to fix the problems with Kansas health system. Indeed, some may be disappointed that so much of my advice is in the form of what not to do. That is because I believe that in pursuing health care reform, legislators should be guided by the Hippocratic admonition "First do no harm."

It is understandable that Kansans are frustrated by the inability of Congress to address the undeniable need for health care reform. Yet it is sadly true that the keys to health care reform lie in federal, not state, legislation. There are limited steps that Kansas can take to make the situation better. But, in the

end, you should be extremely careful to make sure that impatience does not push you into taking steps that will ultimately make the problem far worse, hurting Kansas taxpayers, businesses, health care providers, and perhaps most importantly patients.

I thank you once again for your time and consideration. I would be happy to answer any questions.

Policy Analysis

No. 565 April 5, 2006

Routing

Individual Mandates for Health Insurance
Slippery Slope to National Health Care

by Michael Tanner

Executive Summary

Proposals for achieving universal health insurance coverage are once again receiving serious attention. Among the ideas attracting bipartisan support is an individual health insurance mandate, a legal requirement that every American obtain adequate private health insurance coverage. People who don't receive such coverage through their employer or some other group would be required to purchase their own individual coverage. Those who failed to do so would be subject to fines or other penalties.

Proposals for an individual mandate respond to a legitimate concern about "free riders," the uninsured who nonetheless receive treatment and pass the costs on to taxpayers or individuals with insurance. In practice, however, an individual mandate is likely to be unenforceable because it would involve a costly and complex bureaucratic system of tracking, penalties, and subsidies.

More important, an individual mandate crosses an important line: accepting the principle that it is the government's responsibility to ensure that every American has health insurance. In doing so, it opens the door to widespread regulation of the health care industry and political interference in personal health care decisions. The result will be a slow but steady spiral downward toward a government-run national health care system.

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An individual mandate, if federal, would be an unprecedented expansion of government power.

Introduction

Roughly 46 million Americans are currently uninsured.[1] That has sparked a national debate over how to expand coverage, with many people setting a goal of "universal coverage," that is, every American would have some form of health insurance. Some people have advocated a single-payer system under which the government would administer a taxpayer-financed system. Others have called for an employer mandate, requiring employers to provide their workers with insurance. Both of those approaches have obvious problems that have prevented them from gaining much public support.

As a result, a third approach to universal coverage is now getting serious attention—an individual mandate, a legal requirement that every American obtain adequate private health insurance coverage. People who don't receive such coverage through their employer or some other group would be required to purchase individual coverage.

Such a mandate, if federal, would be an unprecedented expansion of government power. As the Congressional Budget Office noted in 1994, "The government has never required people to buy any good or service as a condition of lawful residence in the United States."[2]

Despite that, proposals for an individual mandate have drawn a surprising degree of support from conservatives. The Heritage Foundation has supported such a mandate for more than a decade.[3] Senate Majority Leader Bill Frist (R-TN) has expressed general support for the idea.[4] Articles favoring an individual mandate have been featured in the *Weekly Standard*.[5] Ron Bailey endorsed the concept on the libertarian website, Reason.com.[6] Perhaps the latest such proposal comes from Gov. Mitt Romney of Massachusetts, an expected Republican candidate for president in 2008.[7]

An individual mandate is an attempt to address real problems in the American health care system. But there is ample reason to be skeptical of that approach.

The Case for a Mandate

Some observers have seen an individual mandate as an achievable step on the road to universal coverage. Having long equated insurance coverage with access to health care and access to better health, they see an individual mandate as producing better health outcomes. They argue, for example, that people will receive more preventive care if they are covered by insurance. In reality, however, the experience of rationing under national health insurance schemes in other countries shows that insurance coverage and access to care are entirely different things.[8] Moreover, evidence that insurance coverage or access leads to better health outcomes is uncertain at best.[9]

Other observers, including economists of all stripes, have tended to embrace individual mandates for another reason. When an individual without health insurance becomes sick or injured, he or she still receives medical treatment. In fact, hospitals are legally required to provide care regardless of ability to pay. Physicians do not face the same legal requirement, but few are willing to deny treatment because a patient lacks insurance.

However, such treatment is not free. The cost is simply shifted to others—those with insurance or, more often, taxpayers. In fact, uncompensated care costs an estimated $40.7 billion per year, with 85 percent of that cost borne by federal, state, and local governments.[10] Thus, to a large degree individuals without health insurance are "free riding" on the rest of us.

In addition, those most likely to go without health insurance are the young and relatively healthy. For example, although 18 to 24 year olds are only 10 percent of the U.S. population, they are 21 percent of the long-term uninsured.[11] For these young, healthy individuals, going without health insurance is often a logical decision. However, this becomes a form of adverse selection. Removing the young and healthy from the insurance pool means that those remaining in the pool will be older and sicker. That results in higher insurance premiums for those who are insured.[12]

Advocates of a mandate argue that if we can mandate automobile insurance in order to protect society from the costs imposed by uninsured drivers, we should be able to do the same for health insurance.[13]

Those are legitimate concerns and cannot be casually dismissed. But regardless of whether a mandate solves legitimate problems in theory, the practical problems of an individual mandate make it likely to be costly and difficult to administer. More important, it would likely set in motion forces that will lead slowly, but almost inevitably, to a government-run national health care system.

The Problem of Enforcement

To enforce a health insurance mandate, government would need some way to determine whether Americans are insured or not and to penalize those who have not complied with the mandate. But government's record of enforcing insurance mandates has not been an overwhelming success. For example, 47 states have laws mandating that drivers purchase automobile liability insurance. Yet roughly 14.5 percent of drivers in those states are uninsured.[14] In some states, such as Texas, the uninsured motorist rate runs as high as 18 percent. As many as 25–30 percent of Los Angeles drivers are uninsured.[15] By comparison, in the three states without mandatory auto insurance, roughly 15 percent of drivers are uninsured. Thus, it would appear that, despite penalties that can run from loss of license to fines as high as $5,000 or even the impounding of vehicles, millions of American drivers have chosen to ignore the mandate.[16] In fact, millions of Americans purchase "uninsured motorist" coverage to protect themselves in an accident in which the other driver is uninsured. It is also interesting to note that the percentage of drivers uninsured despite a mandate is roughly the same as the percentage of Americans who don't have health insurance.[17]

The closest example to a health insurance mandate in the United States is in Hawaii, which has long had a mandate that all employers provide their workers with health insurance. But roughly 10 percent of Hawaiian workers remain uncovered.[18] Even under Canada's national health care system, the government has encountered difficulties in ensuring that everyone is registered or pays required premiums, or both. For example, in British Columbia alone an estimated 40,000 people slip through the cracks. As a result, physicians in that province provide about $5 million to $10 million per year in unreimbursed services to people without insurance.[19] Although that is a tiny amount compared to the cost of treating the uninsured in the United States, it demonstrates the difficulties of forcing compliance with an insurance mandate.

How then will an individual health insurance mandate be enforced? The first problem is to track who is and is not insured. Here again the government's record is unpersuasive. No federal agency invests as much time, money, and effort in tracking Americans as does the Internal Revenue Service. Yet it consistently fails to track down millions of Americans who fail to file tax returns. And every 10 years there is a scandal when the Census Bureau cannot locate several million citizens.

The most commonly suggested solution is to require that Americans submit proof of insurance when they file their federal income taxes. But about 18 million low-income Americans are not required to file income taxes, mostly because their incomes are too low.[20] Another 9 million Americans who are required to file tax returns nonetheless fail to do so.[21] That is potentially 27 million Americans who would not be providing proof of insurance. To deal with that, the centrist New America Foundation, one of the leading advocates of an individual mandate, would mandate that even non–income tax filers submit their proof of coverage.[22] But the foundation provides no plan to deal with those who simply refuse to do so. And, after all, some of the nonfilers will be elderly, homeless, and mentally ill. Others will have changed their address, perhaps multiple times.

Moreover, only about 30 percent of uninsured Americans have been uninsured for a

Government's record of enforcing insurance mandates has not been an overwhelming success.

full year. In fact, nearly 45 percent will regain insurance within four months.[23] Therefore, many people who lack health insurance at some point in the year will be insured at the time they file their taxes. Presumably, the "proof of insurance" could include the length of time that the person was insured, but that would raise the complexity of compliance procedures considerably. It would also increase the incentive to lie.

If the government were able to determine that someone had not purchased health insurance, what penalty would apply? Ideas have been suggested ranging from loss of drivers' licenses to direct fines. However, some sort of tax penalty is the most common approach.

But that is much easier said than done. As Gene Steuerle of the Urban Institute has noted, the administrative and enforcement costs of collecting the penalty would be enormous. The IRS relies largely on voluntary compliance backed up by a slow and cumbersome legal process to collect taxes. And it does not require those with very small amounts of income to file. Even so, as noted above, millions of Americans cheat or fail to file. Collecting a penalty for failure to insure would be much more difficult. "The [IRS] is simply incapable of going to millions of households, many of modest means, and collecting significant penalties at the end of the year," Steuerle warns.[24]

Moreover, many of those who fail to comply with the mandate will be low-income Americans. Nearly one-quarter of those without health insurance today have household incomes of less than $25,000 per year.[25] Those individuals will almost certainly lack the resources to pay any penalty, particularly a lump-sum penalty assessed at year's end.

As an alternative, therefore, some observers have suggested that the penalty be withheld in advance, as part of income tax withholding, then refunded to individuals who provide proof of insurance. However, there is an inherent unfairness to an approach that would impose lower take home pay on Americans regardless of whether they have health insurance. It would also increase compliance costs for employers who presumably have to track how much to withhold on the basis of a worker's marital status and number of children. (To be fair the penalty would have to vary with family size.) If the penalty was a flat rate rather than based on income as are other taxes, that would raise other issues for employers such as how to handle workers with more than one job. Should they pay twice?

Moreover, withholding would do nothing to collect from the unemployed. Yet we know that one reason many people lack health insurance for part of a year is that they are unemployed. Thus, withholding would penalize millions of workers with insurance but miss millions without.

Therefore Steuerle and others suggest some form of carrot-and-stick approach, whereby the penalty would be offset, at least in part, by some form of advance subsidy.[26] However, as discussed below, that has its own set of difficulties.

Finally, some people suggest that rather than impose penalties on individuals who fail to insure themselves, the government simply insure them by assigning them at random to either an insurer or a regional insurance pool (see below). The insurer would then be responsible for ensuring payment through normal collection methods. But, as we've seen, a large number of the uninsured lack insurance for only a short period of time. In many cases they would become insured again during the time it would take to identify, assign, and process them.

States are likely to have an even harder time enforcing a mandate, since they lack both a tracking infrastructure and the ability to impose large tax penalties. Of course, theoretically states could use their income tax systems to levy penalties, but given lower state tax rates, the penalty would be huge compared to the amount of taxes otherwise due. That would make the penalty a difficult proposition politically.

Governor Romney has suggested that Massachusetts withhold state income tax refunds for those without insurance. He would redirect the refund into an escrow

If the government were able to determine that someone had not purchased health insurance, what penalty would apply? Ideas have been suggested ranging from loss of drivers' licenses to direct fines.

account to be held against the individual's future health care expenses.[27] However, for most people, the withheld refund will almost certainly be less than the cost of insurance. The average state tax refund in Massachusetts last year was $401.[28]

In the end, most of the proposed penalties would likely be either too punitive or effective against only the minority of uninsured with moderate or high incomes.

The Complexity of Subsidies

The number-one reason that people give for not purchasing insurance is that they cannot afford it.[29] Therefore, if an individual mandate for health insurance is going to be effective, some form of subsidy for low-income Americans will have to be found. As the New America Foundation notes, "Making basic coverage mandatory for individuals necessitates making coverage available and affordable for all."[30] That raises three important design and implementation questions.

Voucher or Tax Credit?

Should the subsidy be in the form of a voucher payable to the insurer or a tax credit payable to the individual?

The most commonly suggested form of subsidy is a tax credit, most likely refundable. That would take advantage of a system already set up to make payments to millions of individuals. However, the strength of the system is also its weakness. There would be no way to provide the subsidy to those who didn't file tax returns. On the other hand, a voucher payable to insurers would require a potentially costly new administrative structure. Simply mailing the voucher to people who move or without a fixed address poses the potential for administrative chaos.

Flat Amount or Linked to Income?

Should the subsidy be a flat amount for all Americans, or should it be linked to income?

A flat subsidy would be easy to administer and relatively transparent. It would also be costly. After all, any subsidy must be large enough to cover all or most of the cost of insurance for low-income Americans, otherwise the mandate will amount to a highly regressive tax on those least able to pay. The cost of a health insurance policy for a family of four today averages more than $10,000 a year.[31] Clearly, low-income individuals would have difficulty absorbing such costs. Even if the cost could be reduced by mandating a more limited package of benefits or shifting to a high-deductible policy (with or without an accompanying health savings account), the burden on low-income workers would be substantial.[32]

Once the subsidy became available to individuals purchasing insurance on their own, businesses that currently provide their workers with health insurance would either demand equivalent subsidies or drop their health coverage altogether, only too happy to shift the cost of insuring workers to the taxpayer. That behavior is already clearly visible with Medicaid.[33]

That is why proponents of an individual mandate frequently combine it with an employer mandate. (The Heritage Foundation and Governor Romney have resisted that temptation.) Knowing that an employer mandate would ultimately result in lower wages or fewer jobs, proponents generally try to offset such costs by providing subsidies to employers as well as individuals. Thus, the federal government ends up indirectly paying a large part of the cost of health coverage, including coverage for people who are currently insured.

If the subsidy is linked to income or otherwise means tested, there are three ways to do so: 1) projected income for the current year, 2) last year's income, and 3) regularly adjusted weekly or monthly income. Each of those methods has problems.

Guessing future income is simply an exercise in crystal ball gazing. Relying on past income provides an accurate starting point but does not necessarily tell us about an individual's current subsidy need. For example, if

If an individual mandate for health insurance is going to be effective, some form of subsidy for low-income Americans will have to be found.

a person was unemployed last year but finds a job this year, he would be eligible for a subsidy level that he would no longer need. Conversely, a person who was employed last year but lost his job this year would need the subsidy but might not be eligible.

Most traditional welfare programs deal with this problem by basing eligibility on weekly or monthly reporting. That provides for flexibility in dealing with income fluctuations and changes in circumstance. However, verification of such frequent reports is costly and manpower intensive, resulting in poor monitoring and widespread inaccuracy, not to mention outright fraud. There is also the question of who would be responsible for monitoring eligibility on a short-term basis. The IRS is not set up to deal with weekly or monthly income reports. State welfare agencies do so now in the case of Temporary Assistance to Needy Families, Medicaid, and similar programs, but those agencies have nowhere near the manpower or infrastructure it would take to collect and verify income information from every household in the state every week or month. Such a requirement would quickly bankrupt most states, to say nothing of the difficulties involved in coordinating the information, once collected, with the federal subsidizer.

However subsidies are ultimately calculated, they are apt to be expensive for taxpayers. By some estimates, the initial cost of subsidies nationally would top $75 billion per year.

Risk Rated?

Should the subsidies be risk rated or otherwise take into account the higher insurance premiums that are charged to families or individuals with preexisting conditions or other high-risk factors?

High-risk individuals cost more to insure than do individuals who are young and healthy. If their subsidy is not adjusted, they will face higher out-of-pocket costs, in some cases, prohibitive ones.

If people receive a higher subsidy simply because they are paying higher premiums, there is no burden on either the consumer to be a wise consumer or on the insurance plan to be efficient. Without intrusive government oversight, there is no reasonable way to determine whether a plan is charging higher premiums because it is insuring families with higher risks, because it is inefficient, or simply because it is attempting to maximize its profit margin.

However subsidies are ultimately calculated, they are apt to be expensive for taxpayers. By some estimates, the initial cost of subsidies nationally would top $75 billion per year.[34] The subsidies under Governor Romney's plan for Massachusetts would cost between $700 million and $1.2 billion.[35] To some degree savings from uncompensated care would offset those costs. On the other hand, increased coverage would almost certainly lead to increased usage, driving up overall health care costs and necessitating increased subsidies.

Mandate Creep

To implement an insurance mandate, legislators and administrators will have to define what sort of insurance fulfills that mandate. Not surprisingly, given the early stage of the debate, most proposals have been vague about what sort of benefit package would meet the minimum requirements for the mandate. But there are a few proposals that contain enough detail to let us assess what a mandated package might look like.

For example, the New America Foundation suggests that the Blue Cross Blue Shield Standard Benefit offered under the Federal Employee Health Benefits Program provides a good model for the minimum benefits package.[36]

A plan developed by Blue Cross Blue Shield of California calls for "independent medical professionals" to develop the minimum benefit package, but specifies that it should include preventive care, physician services, hospital care, and prescription drugs.[37]

Governor Romney would give people a choice of plans offered by two government-created purchasing pools. Insurers participating in the pools would be able to offer what the governor has described as low-cost, no-frills plans, including plans with high deductibles.[38] Governor Romney has estimated that those

plans would cost between $134 and $160 a month, after taxes, per person, or between $350 and $500 for a family plan.[39] Some of the cost would be offset by subsidies, on a sliding scale, so that a single person making $23,925 a year would pay $18.46 per week for health insurance.[40] That would still be nearly $1,000 per year, a substantial burden for someone in that income range.

The Heritage Foundation has taken perhaps the least prescriptive approach, with a mandate for catastrophic coverage, defined essentially as a "stop loss" policy protecting a family against total health care costs above a certain level.[41]

Whatever the initial minimum benefits package consists of, special interests representing various health care providers and disease constituencies can certainly be expected to lobby for inclusion under any mandated benefits package. To see this in action, one simply has to look to state mandates for health insurance benefits. The number of laws requiring that all insurance policies sold in a state provide coverage for specified diseases, conditions, and providers has been skyrocketing. In the 1960s there were only a handful of such mandates, but today there are more than 1,800.[42] The list includes mandates for coverage of hair transplants (Connecticut, Massachusetts, Maryland, Minnesota, Missouri, New Hampshire, and Oklahoma), massage therapy (Florida, Maryland, New Hampshire, and Washington), and pastoral counseling (Maine and North Carolina).[43]

Or consider Oregon's attempt to prioritize Medicaid services. In 1992 Oregon guaranteed all state residents under the poverty line a basic level of health care. At the same time, because funding was limited, the Oregon Health Services Commission drafted a priority-ranked list of medical services available to Oregonians. The state would fund services deemed priority on the basis of such factors as cost, duration of a treatment, benefit, improvement in the patient's quality of life, and community values. Services that did not qualify under those criteria would not be funded.[44] However, political calculations quickly became part of the ranking process, with the program a battleground for interests associated with various disease constituencies and health care specialties. Groups battled each other to make sure that their needs or services were included in the list of covered services. The list was repeatedly revised to reflect, not the best medical judgment, but outside pressure. The legislature repeatedly intervened. The U.S. Office of Technology Assessment concluded that Oregon's prioritization plan "has not operated as the scientific vessel of rationing that it was advertised to be. Although initial rankings were based in large part on mathematical values, controversies around the list forced administrators to make political concessions and move medical services 'by hand' to satisfy constituency pressures."[45]

And when the Clinton administration proposed a minimum benefits package as part of its 1993 health care reform plan, provider lobbying groups spent millions of dollars in advertising calling for the inclusion of specific provider groups or coverage of specific conditions.

Public choice dynamics is such that providers (who would make money from the increased demand for their services) and disease constituencies (whose members naturally have an urgent desire for coverage of their illness or condition) will always have a strong incentive to lobby lawmakers for inclusion in any minimum benefits package. The public at large will likely see resisting the small premium increase caused by any particular additional benefit as unworthy of a similar effort. It is a simple case of concentrated benefits and diffuse costs.

Spiraling Downward toward National Health Care

Individual mandates cross an important practical and philosophical line: once we accept the principle that it is the government's responsibility to ensure that every American has health insurance, we guarantee even more government involvement with and control over large portions of our health care system. Compulsory, government-defined insurance opens the door to even more widespread regu-

Public choice dynamics is such that providers and disease constituencies will always have a strong incentive to lobby lawmakers for inclusion in any minimum benefits package.

Once we accept the principle that it is the government's responsibility to ensure that every American has health insurance, we guarantee even more government involvement with and control over large portions of our health care system.

lation of the health care industry and political interference in personal health care decisions. The result will be a slow but steady spiral downward toward a government-run national health care system.

To see this in action, one has only to look at the details of the comprehensive proposals containing individual mandates. For example, the New America Foundation would require insurers to accept all comers without any waiting period for preexisting conditions. The foundation also embraces community rating (a prohibition on charging different premiums based on factors such as age, sex, occupation, or health status) and would prohibit any risk rating of premiums.[46]

The New America Foundation also calls for the creation of "community purchasing pools" that would provide government-approved insurance plans to individuals on a collective basis.[47] Governor Romney's plan also calls for such pools, which were once a key ingredient of the Clinton health care plan.[48] (Massachusetts already has community rating.)

The pools would not actually be insurers. Insurance would still be provided by the private sector. Rather, the pools would function as clearinghouses, a sort of wholesaler or middleman, matching customers with "approved" providers and products. They would also allow small businesses and individuals to pool their resources to take advantage of the economies of scale available to large group plans.

However, when such pools are combined with community rating and restrictions on other types of risk rating, they can act as significant barriers to competition in the insurance industry. Since plans participating in the pools must offer the same package of core benefits, they can compete on the basis of services offered only at the margins. Price competition is also extremely limited since so many of those purchasing from the pools have their purchase costs subsidized. And the inability of insurers to reduce costs by managing risks will act as a further barrier to price competition.

Ultimately, the pools will squeeze out insurers outside the pools. That is particularly likely if insurers outside the pools are prohibited from offering lower premiums, as recommended by the New America Foundation.[49] In the end, the pools will become monopsony purchasers of health insurance, turning insurers into little more than public utilities.

These proposals for regulating the insurance market should not be seen as independent from the individual mandate; they are a direct outgrowth of it. "If you want to go down the road of an individual mandate, it's necessary to reform the entire health insurance system to make sure healthy people can get affordable coverage and sick people are not priced out of the market," says Gail Shearer of Consumers Union.[50] And because the mandate restricts the ability of the market to discipline itself, increased regulation will be seen as the only way to meet that goal.

In addition, we have already seen that there will be enormous special interest pressure to add benefits to the mandated package. As more benefits are added, the cost of the mandate will increase. That will place legislators in a very difficult position. If they increase subsidies to keep pace with the rising cost of the mandate, the cost of the program will explode. On the other hand, if they hold subsidies steady, the increased cost will be borne by consumers, who will have no choice but to continue purchasing the ever more expensive insurance. Since consumers would have little or no leverage over insurers (they can no longer refuse to buy their products), they can eventually be expected to turn to the only entity that can hold down their costs—the government. Attempts to scale back benefits would certainly meet political opposition from powerful constituencies and complaints about "cuts." The only other alternative would be for the government to intervene directly by capping premiums.

To see this dynamic in action, just look at the recent Bush administration budget proposals for Medicare. Faced with exploding program costs as a result of the president's prescription drug program, the administration has reacted, not by cutting back on benefits, but by cutting back on payments to providers, de facto price controls.[51]

Insurers unable to charge more for an increasingly expensive product can be expected to trim costs by cutting back on their reimbursement rates to hospitals and physicians. The result will ultimately be rationing and a lack of available health care goods and services.

An individual mandate, therefore, should not be seen in a vacuum. It is more akin to the first in a series of dominoes. By distorting the health care marketplace, an individual mandate would set in place a cascading series of additional mandates and regulations resulting, ultimately, in a government-run health care system.

Conclusion

There is no easy answer to the free-rider problem. Human nature being what it is, as long as we make the decision to help those who cannot (or will not) pay for their own health care, we will provide an incentive for people to take advantage of society's generosity. Although universal coverage schemes sound desirable in theory, in practice none is likely to reach every American, and all carry significant price tags, both in terms of dollars and in terms of unintended consequences for the health care system as a whole. On the other hand, being a compassionate society, we are unlikely to refuse health care to those without insurance (or other resources with which to pay for it) as punishment for their lack of foresight.

This conundrum, how to provide care to those who truly need help while discouraging free riding, must be dealt with whether the decision to provide for the needy is made by government or civil society (although government complicates the issue when it mandates that providers provide uncompensated care thereby preempting experimentation with ways to discourage free riding). Rather than let one government mandate spawn another (and another, and another . . .), the best, although admittedly imperfect, answer might be to make existing government mandates more flexible as a way to encourage more innovative approaches to dealing with the free-rider problem.

An individual mandate would be an unprecedented expansion of government power and intrusion into the American health care system. As the CBO puts it:

> An individual mandate has two features that, in combination, make it unique. First, it would impose a duty on individuals as members of society. Second, it would require people to purchase a specific service *that would have to be heavily regulated* by the federal government (emphasis added).[52]

On a practical level, such a mandate is likely to prove unenforceable. More important, an individual mandate will almost certainly lead to a cascading series of additional mandates and regulations resulting in a government-run health care system. However we ultimately deal with the uninsured and the free-rider problem, we should bear in mind the Hippocratic Oath: "First do no harm." An individual mandate, then, is clearly not the way to go.

On a fundamental level we must shift the health care debate away from its single-minded focus on expanding coverage to the bigger question of how to reduce costs and improve quality. That will require the introduction of market mechanisms to give consumers more control over and responsibility for their health care decisions.

In doing so, we can actually increase coverage and reduce the free-rider problem. In particular, if young, healthy people are able to purchase low-cost catastrophic insurance, they are more likely to see becoming insured as in their self-interest. And, to the degree that health care and health insurance become less expensive, more low-income people can be brought into the system.

That would be a better, more realistic, and far less risky approach than individual mandates.

Notes

1. Carmen DeNavas-Walt, Bernadette Proctor, and Cheryl Hill Lee, "Income, Poverty, and Health

By distorting the health care marketplace, an individual mandate would set in place a cascading series of additional mandates and regulations resulting, ultimately, in a government-run health care system.

Insurance Coverage in the United States, 2004," U.S. Census Bureau, August 2005, http://www.census.gov/prod/2005pubs/p60-229.pdf.

2. Robert Hartman and Paul van de Water, "The Budgetary Treatment of an Individual Mandate to Buy Health Insurance," Congressional Budget Office memorandum, August 1994.

3. The Heritage Foundation first spelled out the details of its proposal in 1994. Stuart Butler, "The Heritage Foundation Proposal," presentation to a Heritage Foundation conference on "Is Tax Reform the Key to Health Care Reform?" Heritage Lecture no. 298, October 23, 1990. However, it has reaffirmed its support for an individual mandate as recently as 2003. Stuart Butler, "Laying the Groundwork for Universal Health Care Coverage," Testimony before the Senate Special Committee on Aging, March 10, 2003. In addition, the Heritage Foundation hosted a forum for Governor Romney this year, during which they implied support.

4. Bill Frist, "Transforming Health Care: A Patient-Centered, Consumer-Driven and Provider-Friendly Vision," Address to National Press Club, July 12, 2004.

5. Ross Douthat and Reihan Salam, "The Party of Sam's Club," *Weekly Standard*, November 14, 2005, http://www.weeklystandard.com/Content/Public/Articles/000/000/006/312korit.asp.

6. Ronald Bailey, "Mandatory Health Insurance Now!" November 2004, http://www.reason.com/0411/fe.rb.mandatory.shtml.

7. Associated Press, "Romney Plan Would Require All to Buy Health Insurance . . . Or Else," June 23, 2005.

8. For example, one million Britons are waiting for admission to National Health Service hospitals at any given time, and shortages force the NHS to cancel as many as 100,000 operations each year. Roughly 90,000 New Zealanders are facing similar waits. In Sweden, the wait for heart surgery can be as long as 25 weeks, while the average wait for hip replacement surgery is more than a year. And in Canada more than 800,000 patients are currently on waiting lists for medical procedures. See Michael Cannon and Michael Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington: Cato Institute: 2005), pp. 36–37.

9. See, for example, Helen Levy and David Meltzer, "What Do We Really Know about Whether Health Insurance Affects Health?" in *Health Policy and the Uninsured*, ed. Catherine McLaughlin (Washington: Urban Institute, 2004), pp. 179–204.

10. Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured, May 10, 2004.

11. Rob Stewart and Jeffrey Rhoades, "The Long-Term Uninsured," U.S. Census Bureau, Research Note, September 2004, http://aspe.hhs.gov/health/long-term-uninsured04/report.pdf.

12. This argument is true only if there are cross-subsidies in existing pools. If everyone's rates are actuarially fair, then young people's explicit or implicit premiums do not result in lower or higher premiums for anyone else. These two views of health insurance—ex ante versus no ex ante redistribution—are actually the basis for much analysis and policy prescription in health care.

13. This is an imperfect analogy, however. First, it has long been recognized that driving is a privilege, subject to all manner of regulatory requirements. If one does not like the regulations, including an insurance mandate, one can choose not to drive. A health insurance mandate would not generally give people such a choice. Second, the reason states mandate auto insurance is for the protection of *others* rather than oneself. Most states do not mandate that you carry insurance for your own injury or repair costs.

14. Greg Kelly, "Can Government Force People to Buy Insurance?" Council for Affordable Health Insurance, Issues & Answers no. 123, March 2004, citing data from the Insurance Research Council, http://www.cahi.org/cahi_contents/resources/pdf/n123GovernmentMandate.pdf.

15. Stephanie Jones, "Uninsured Drivers Travel under the Radar," *Insurance Journal*, August 18, 2003.

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19. Heather Kent, "BC Doctor Seeks Class-action Suit over Payment for Uninsured Patients," *Canadian Medical Association Journal* 163, no. 9 (October 31, 2000): 1184.

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27. Office of the Governor, "Massachusetts Health Care Reform," PowerPoint presentation; see also Edmund Haislmaier, "Mitt's Fit," *National Review Online*, January 27, 2006, http://www.nationalreview.com/comment/haislmaier200601271110.asp.

28. "2005 Personal Income Tax Filing Season Information," Commonwealth of Massachusetts Department of Revenue, http://www.massdor.com/options/filingseasoninfo.htm.

29. "The Uninsured: A Primer, Key Facts about Americans without Health Insurance," Kaiser Family Foundation, December 2003

30. Calabrese and Rubiner, p. 5.

31. Julie Appleby, "Average Family Health Policy Nears $11,000," *USA Today*, September 14, 2005. Of course for most people much or all of this cost is hidden, paid by their employer. But people who do not receive employer-paid health insurance—the subjects of an individual mandate—would have to bear the cost themselves.

32. For example, the average cost of an HAS-qualified family policy is roughly $7,900. "Employer Health Benefits 2005 Annual Survey," Kaiser Family Foundation, p. 97, http://kff.org/insurance/7315/upload/7315.pdf.

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

34. Kenneth Thorpe, "An Analysis of the Costs and Coverage Associated with Blue Shield of California's Universal Health Insurance Plan for All Americans," Emory University, June 11, 2003.

35. Scott S. Greenberger, "Romney Eyes Penalties for Those Lacking Insurance," *Boston Globe*, June 22, 2005, citing estimates from the Blue Cross-Blue Shield Foundation.

36. Calabrese and Rubiner.

37. Blue Shield Association of California, "Blue Shield Offers Healthcare Plan for Universal Coverage with Universal Responsibility," news release, December 3, 2002. See also Kenneth Thorpe, "An Analysis of the Costs and Coverage Associated with Blue Shield of California's Universal Health Insurance Plan for All Americans," Blue Shield Association of California, June 11, 2003.

38. There is less to that claim than meets the eye, however. Plans would still be required to use community rating, retain some—though not all—of the state's mandated benefits, and cap deductibles at $1,000. That is far from a high deductible in a high-tech, high-cost health care state like Massachusetts. Indeed, it is estimated that half of all Massachusetts residents would meet this deductible. Arnold Kling, "Wrong State for Market-Based Health Insurance," *EconLog*, November 26, 2005.

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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 discouraging 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]

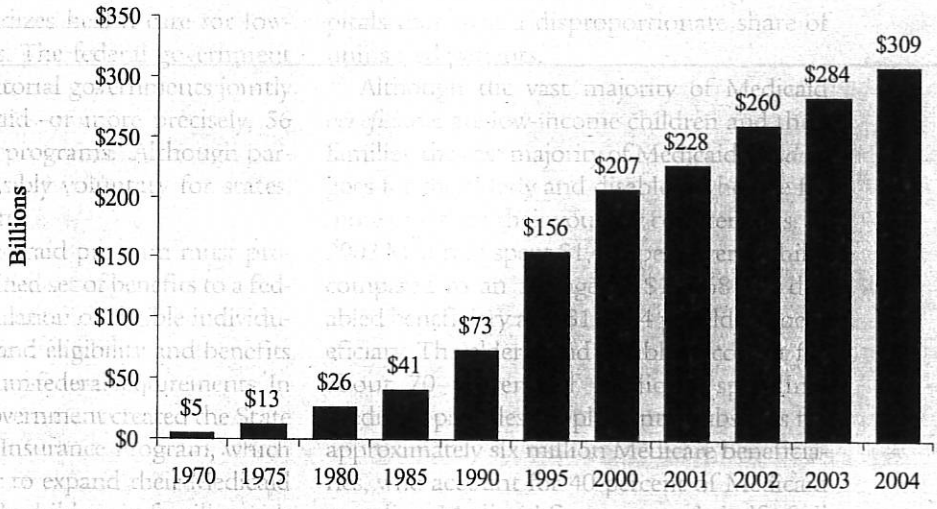
A number of factors drive growth in Medicaid spending. Many of those will be discussed later. A large share of the growth comes from recent expansions of state Medicaid programs. Encouraged by federal State Children's Health Insurance Program funds and overflowing tax coffers, states greatly expanded 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.

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 rolls[11] 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 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.

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-

Because eligibility depends on income and assets, many beneficiaries become eligible by avoiding self-help—such as striving to earn more or save more.

In 1993 Medicaid reduced asset holdings among eligible households by the equivalent of $1,600 to $2,000 in today's dollars.

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 holdings[21] 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.

Medicaid encourages employers of low-income workers not to offer coverage and encourages low-income workers not to enroll in private coverage.

Evidence strongly suggests that states have expanded Medicaid beyond its original purpose of providing medical assistance to the truly needy.

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

The tax burden that Medicaid places on low-income earners should not be taken lightly.

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.

Medicaid increases the price of non-Medicaid prescriptions by 13.3 percent over and above what they otherwise would be.

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?

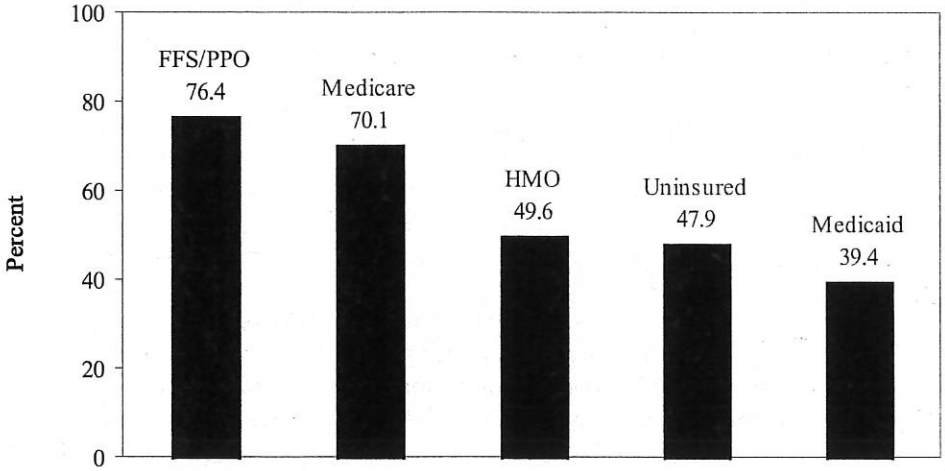
Choice of Providers

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]

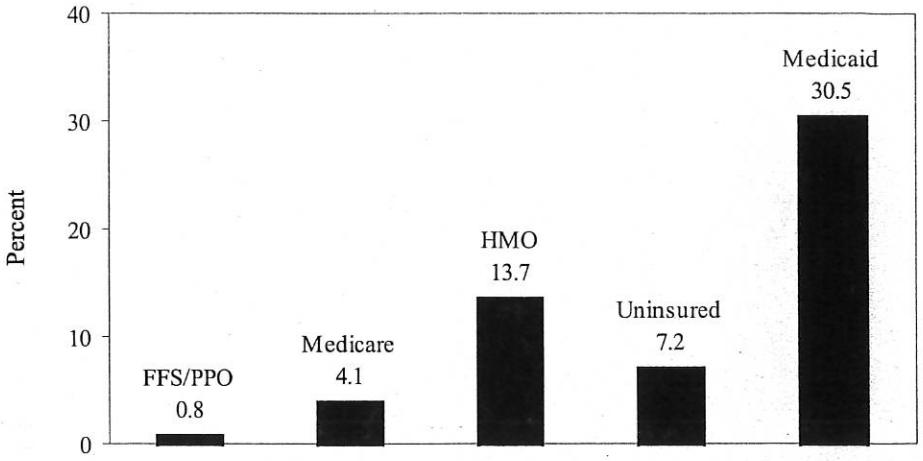
The unseen costs of Medicaid's poor quality of care fall hardest on women. Medicaid subsidizes health care for 1 of 10 American women, who comprise 71 percent of adult beneficiaries.[58] Women with Medicaid coverage have more difficulty finding a doctor than uninsured women and significantly more difficulty 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 substitute Medicaid for private health coverage, the program may actually reduce the quality of care they receive.

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.

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 coverage, 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 mets 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.

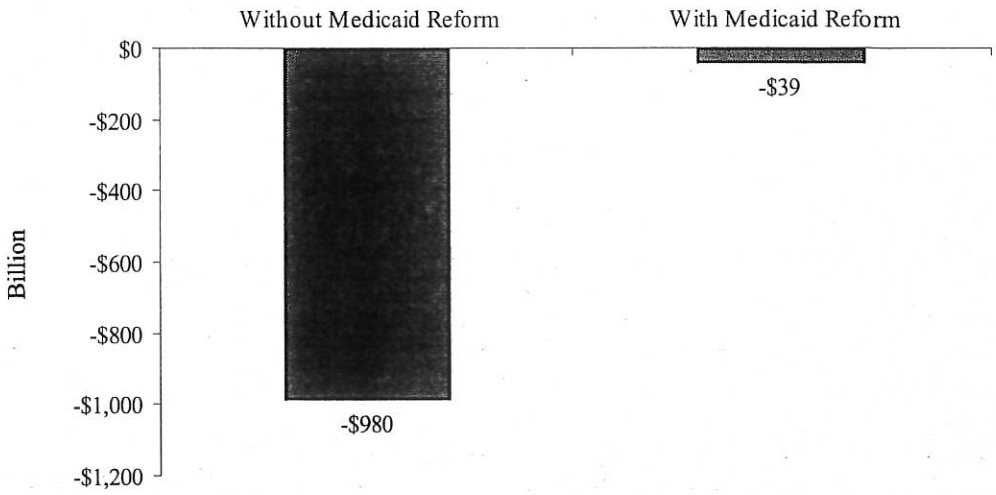
An Agenda for Medicaid Reform

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.

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.

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.

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.

9. Anita Wadhwani, "Bredesen's 2003 Revisions to TennCare Now Block Him," *Tennesseean.com*, July 6, 2005, http://www.tennessean.com/apps/pbcs.dll/article?AID=/20050706/NEWS0204/507060401.

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.

29. Gestur Davidson et al., "Public Program Crowd-Out of Private Coverage: What Are the Issues?" Robert Wood Johnson Foundation

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.

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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.

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

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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.

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