

Paying Beneficiaries, Not Providers

Transforming Medicaid and Medicare into poverty-fighting programs would greatly improve Americans' health.

BY DAVID A. HYMAN AND CHARLES SILVER

Over the past few decades, retirement savings has shifted from a defined-benefit model to a defined-contribution model. If we look at the major social welfare programs operated by the federal government, we see a very different pattern. Two of those programs, Medicaid and Medicare (both enacted in the mid-1960s), are defined-benefit programs, which pay health care providers for specific goods and services. A third, substantially older, major federal social welfare program, Social Security, is a defined-contribution/cash-transfer program, which gives beneficiaries a fixed amount of money and lets them decide how to spend it.

Our continued reliance on a defined-benefit approach for Medicaid and Medicare when we simultaneously use a defined-contribution approach for Social Security raises obvious questions. What do we know about the effects of Medicaid and Medicare? Is there a case for transforming them into programs more like Social Security? Which approach better ensures good health?

MEDICAID AND MEDICARE'S HEALTH EFFECTS

We begin by focusing on the effects of Medicaid and Medicare on health. Medicaid financially assists impoverished Americans by paying for their medical treatments. Medicare does the same for senior citizens. Not surprisingly, health care providers are enthusiastic supporters of both programs because they relieve them of much of the burden of providing charity care. Provider preferences aside, popular support for both programs has more

to do with the collective belief that poor people and the elderly suffer from unmet medical needs and will enjoy better health when their access to providers is improved.

Unfortunately, it has proven to be quite difficult to document health-improving effects from Medicaid. In 2017, the Kaiser Family Foundation—a staunch supporter of Medicaid—summarized the findings of the Oregon Health Insurance Experiment, which randomly sorted applicants into a group that received Medicaid and a group that did not. Evidence of an effect on physical health was mixed at best. The main positive effects were increased detection of diabetes and use of diabetes medication. Although members of the recipient group reported improved mental health, that effect was likely due (at least in significant part) to a reduction in beneficiary concern with financial insecurity related to the risk of health care-related expenditures.

Studies of the Medicaid expansion under the 2010 Patient Protection and Affordable Care Act (ACA) have also had difficulty identifying material improvements in health. A 2018 systematic review/meta-analysis found that the main effects of the ACA's Medicaid expansion on health outcomes were improvements in *self-reported* mental health and general health. As in Oregon, *documented* improvements in beneficiaries' physical health were few and far between. A 2019 Kaiser Family Foundation literature review reached similar conclusions, although another 2019 study found evidence of a reduction in mortality in states that expanded Medicaid.

One important reason for the paucity of positive findings is that health status is a function of a wide array of nonmedical factors including social, behavioral, environmental, and genetic components. The standard estimate is that nonmedical factors account for at least 80% of overall health outcomes, meaning that even substantial investments in health care are unlikely to result in dramatic improvements.

Medicaid is also unlikely to improve population health because

DAVID A. HYMAN is the Scott K. Ginsburg Professor of Health Law and Policy at Georgetown University Law Center and an adjunct scholar at the Cato Institute. CHARLES SILVER holds the Roy W. and Eugenia C. McDonald Endowed Chair in Civil Procedure in the School of Law at the University of Texas, Austin and is an adjunct scholar at the Cato Institute. This is condensed from their forthcoming article, "There Is a Better Way: Make Medicaid and Medicare More Like Social Security," *Georgetown Journal of Law & Public Policy*.



a lot of Medicaid's budget is spent on things that are unlikely to generate quantifiable health improvements. For example, a substantial fraction of Medicaid's budget is used to house, feed, and care for poor, elderly beneficiaries. The services that nursing homes and other businesses provide for people who are elderly or disabled are certainly valuable, but their effects on health, longevity, and mortality are likely small and hard to assess.

Similar difficulties have beset efforts to measure the effects of Medicare on health. Because all Americans over age 65 are eligible for the program, there is no control group. Researchers Amy Finkelstein and Robin McKnight studied the health effects of Medicare and were "unable to reject the null hypothesis that, in its first 10 years, Medicare had no effect on elderly mortality." A more recent study by David Card, Carlos Dobkin, and Nicole Maestas found that the all-cause mortality rates and self-reported health status for people immediately before and after the Medicare eligibility threshold (age 65) are quite similar, but there was evidence of a Medicare-associated reduction in mortality for a subset of hospital admissions.

What about the effects of health insurance on populations other than Medicaid and Medicare beneficiaries? Robert Weathers and Michelle Stegman studied previously uninsured applicants for Social Security Disability Insurance who were randomly assigned to three groups. One group was excluded from health insurance coverage, while the other two received health insurance policies with varying benefits. They found evidence of improvements in mental health for the treatment groups, but no statistically significant reduction in mortality. A study of the near-elderly by Bernard Black, José-Antonio Espin-Sanchez, Eric French, and Kate Litvak similarly found little evidence that the insured have lower mortality or improved health in either the short or long run.

In interpreting these findings, it is important to note that many uninsured individuals do receive some health care. So, these studies are measuring the incremental (marginal) effect of having health insurance compared to a population that lacks insurance but has some access to health care. Consistent with this observation, Finkelstein and McKnight note that part of the explanation for their (null) findings is that "prior to Medicare,

elderly individuals with life-threatening, treatable health conditions sought care even if they lacked insurance, as long as they had legal access to hospitals.” Similarly, Black et al. note that given the same dynamic, “much of the additional care the [uninsured] would receive if insured could provide limited marginal benefit.”

Where does that leave us? Most of the coverage gains from the enactment of the ACA came from the Medicaid expansion. But the fixation of the Obama administration on expanding health insurance coverage is problematic given that Medicaid does not seem to do much to reduce mortality or improve health.

EFFECTS OF CASH TRANSFERS

Even if the connection between coverage and health were stronger than it seems to be, the correct comparison is not between Medicaid/Medicare and nothing, it is between Medicaid/Medicare and cash transfers structured like Social Security. Stated differently, to assess the relative merits of in-kind benefits versus cash transfers, one must compare the consequences of a defined-benefit approach (Medicaid and Medicare) with the consequences of a defined-contribution approach (Social Security) on all the relevant outcomes.

Unfortunately, no study makes this comparison. But it is clear that being economically disadvantaged is bad for one’s health. As we discuss in a forthcoming article in the *Georgetown Journal of Law & Public Policy*, in 2018 alone reports showed that food insecurity is a significant problem for Medicaid recipients; that low income explains the racial disparity in post-heart attack survival rates better than race does; that loss of food stamps is associated with poor health; and that teenagers from low-income families are more likely than their affluent peers to be obese, inactive, have poor nutrition, and use tobacco. These findings (and many more) indicate the importance of the social determinants of health and the potential of income subsidies to address some of these problems. Given these considerations, wealth transfers that alleviate poverty and facilitate investments in the social determinants of health have the potential to improve population and individual health more than equivalent expenditures on medical treatments.

The recognition that health and well-being are greatly influenced by factors other than medical treatments poses a challenge for Americans who are accustomed to thinking about social welfare programs in siloed ways. From this siloed perspective, if the poor have unmet legal needs, the obvious solution (at least to most commentators) is to require lawyers or law students to provide services for free. If the poor are hungry, the obvious answer (again to most commentators) is food stamps or laws requiring grocery stores and restaurants to donate unsold food. Finally, if the poor suffer from bad health, the obvious response is to require hospitals to provide charity care. These strategies have become conventional wisdom—unquestioned and unassailable.

Although approaches like these surely do some good, they are addressing symptoms, not causes. Poverty is the common driver of all these problems. In our view, the best solutions to these

discrete problems are strategies that address poverty directly by improving the economic circumstances of the poor and by making the goods and services that poor people need more affordable. If Medicaid and Medicare were remodeled along the lines of Social Security, both programs would perform these functions far more effectively than they currently do.

FIGHTING POVERTY WITH MEDICAID AND MEDICARE MONEY

Social Security is our nation’s largest social welfare program. In 2018, it doled out approximately \$988 billion to nearly 63 million beneficiaries. Medicare and Medicaid rival Social Security in size. In 2018, Medicare paid out \$731 billion in benefits on behalf of approximately 43 million beneficiaries. In 2017, combined federal and state spending on Medicaid was \$553 billion, which covered over 65 million people. There is some overlap between the beneficiary populations covered by these programs, but about 99 million Americans are covered by at least one of them. By comparison, all other spending on welfare programs equaled only about \$350 billion—less than one-sixth of the \$2.3 trillion spent on Social Security, Medicaid, and Medicare combined.

By common consensus, Social Security is our country’s most successful antipoverty program. The conventional wisdom, which is undoubtedly exaggerated, is that Social Security raises more than 20 million people above the federal poverty level each year. Tax policy (including reduced rates at the lowest income levels, the Earned Income Tax Credit [EITC], and the Child Tax Credit) has also helped reduce the number of Americans living in poverty. By contrast, Medicaid and Medicare have had only a small and indirect effect on poverty.

If Medicaid and Medicare were to give beneficiaries money instead of services, the effect on poverty would be dramatic. In 2014, the United States spent about \$5,700 per Medicaid beneficiary. Using all Medicaid beneficiaries as the divisor, a four-person family whose only income came from Medicaid would rise to within \$1,100 of the federal poverty line. Because family size averages 3.7 persons for families on public assistance, cash transfers from Medicaid would make quite a difference in household income. However, if we focus Medicaid spending on the population below the federal poverty level, the poverty-reducing effect would be magnified. In 2017, Medicaid spending totaled roughly \$553 billion. Dividing that amount by 39.7 million—the number of Americans who lived below the official poverty level in 2017—yields a payment of \$13,929 per person, considerably more than the \$12,488 poverty cutoff for a single person that year. If Medicaid just distributed money, its budget alone would be large enough to reduce the official poverty rate to zero.

What about Medicare? In 2014, it spent nearly \$11,000 per beneficiary. That same year, the federal poverty line was \$11,670 for a single person, \$15,730 for a family of two, and \$23,850 for a family of four. Had the Medicare benefit been distributed in cash rather than services, the benefit would have brought all single seniors to

within \$1,000 of the poverty line and elevated all senior couples to more than \$6,000 over it. Stated differently, converting Medicare into a cash-transfer plan would almost completely eliminate the problem of poverty among senior citizens.

Poverty is a money problem. Economically disadvantaged people have too little of it. The most direct solution is to give them more. Medicaid and Medicare are decidedly indirect solutions to the problem of poverty. These programs provide access to medical treatments, which poor people may or may not need and whose monetary value is difficult to assess. Consequently, these programs ameliorate poverty far less effectively than direct cash transfers.

BENEFICIARIES' PREFERENCES

The superiority of cash becomes even clearer when one considers that Medicaid and Medicare only protect beneficiaries from health care costs. Other losses are not covered. Cash transfers provide protection against financial losses of all sorts, including those that may worry people far more than health care costs.

A quick hypothetical illustrates the point. Suppose that poor

involved feel more virtuous, but doing so prevents beneficiaries from improving their lot in life as much as they could.

This is a real problem. Consider the recent proposal to allow Medicare Advantage plans to cover nonmedical services that elderly people need, “such as help with chores, safety devices and respite for caregivers.” If Medicare doled out cash, this reform would not be needed; the elderly would be able to purchase any nonmedical services they desired.

Program administrators recognize that Medicaid is failing to meet beneficiaries' needs, and are diversifying the range of offered services. According to a 2019 article, “plans are starting to pay for non-traditional services such as meals, transportation, housing and other forms of assistance to improve members' health and reduce medical costs.” Some plans will even help high school dropouts earn their GEDs.

Unfortunately, not all “mismatches” are being addressed or can be addressed within the confines of Medicaid or Medicare. One reason for this is that the number of mismatches is extraordinarily great, meaning that most (if not all) beneficiaries are saddled with

suboptimal arrangements. For example, elderly beneficiaries may prefer home- and community-based alternatives to nursing homes. Medicaid covers nursing homes but is prohibited from using program funds to pay recipients' rent or room and board, frustrating beneficiaries' ability to choose accommodations that best fit their needs.

Beneficiaries are not likely to gain greater freedom of movement anytime soon. The nursing home industry will oppose all efforts to loosen existing restrictions. If

Medicaid delivered cash instead of services, elderly people would be free to move out of nursing homes—and nursing home owners would be powerless to prevent them from doing so.

The desire to prevent program beneficiaries from using Medicaid dollars to buy what they want likely reflects the belief that some beneficiaries will spend the money unwisely, coupled with the paternalistic desire to protect people from themselves. Some people will make bad decisions, but it is easy for well-educated, upper-middle-class policy wonks and academics to exaggerate the tendency of economically disadvantaged people to squander resources. Studies of the spending habits of families receiving public assistance show that food, housing, and transportation account for the bulk of their outlays, followed by clothing, health care, personal insurance, and pensions. A study of the EITC similarly found that recipients allocated their refunds carefully and focused their spending on essential needs.

It is also easy for well-educated, upper-middle-class policy wonks and academics to exaggerate the government's ability to allocate resources more appropriately than welfare recipients. If the government were run by angels, perhaps that would be the case—but the government's priorities reflect the interests of the providers that

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people were offered a choice between a Medicaid benefit that costs \$4,000 and \$4,000 in cash. Which would they choose? Presumably, most would sort themselves according to the value they attach to the in-kind benefit. Those who value the service more than \$4,000 would choose the benefit; those who value the cash more highly would take the money. Which group is likely to be larger?

If you said the group whose members would prefer the cash, you are in good company. Bill Gardner, Timothy Jost, and Harold Pollack—three prominent advocates for Medicaid—conceded in an essay in the progressive magazine *The American Prospect* that “given the choice between a Medicaid benefit that costs \$4,000 and \$4,000 in simple cash, many or most low-income people might well prefer to take the cash.” Oregon's Medicaid experiment supports this position too. When researchers measured the financial value of the services Oregon supplied, their “estimates indicate[d] a welfare benefit from Medicaid to recipients that [was] below the government's cost of providing Medicaid”—at most, 40¢ on the dollar.

Health policy experts prefer to ignore the reality that Medicaid recipients value other goods and services more highly than health care coverage. Our stubborn collective insistence on giving medical services to people who would rather have cash may make those

dominate the political process. These providers want to be paid for delivering whatever services they happen to perform, including services that match recipients' needs and desires less well than those that recipients would choose if they were in charge.

WHAT ABOUT BAD CHOICES?

Of course, some welfare recipients do spend money imprudently, and the volume of imprudent spending might increase if Medicaid benefits were paid out in cash. Even sensible spenders might wind up short of money. A person who must choose between health insurance and transportation to get to work may quite reasonably opt for the latter. When misfortune strikes, that person may require charity care, too.

Before discussing possible strategies for dealing with problems like these, two points are worth noting. First, no social welfare program will work perfectly. Medicaid and Medicare certainly do not. The touchstone for program evaluation should be the least bad institutional arrangement that will do the job, not perfection. Second, problems like those just described already exist, even in a world where we spend \$1.25 trillion per year on Medicare and Medicaid.

What about imprudent spending? One obvious approach is to focus on the minority of recipients who are the source of the problem. When a Medicaid beneficiary who receives cash needs medical care for which he or she cannot pay (directly or by privately purchased insurance), the provider would file a report with the government, which would pay for the services at the same market rate the individual would have been charged. Then, the government would subject the beneficiary's future cash transfers to control by a guardian, who would regulate their use. The government could also "claw back" the cost of treatment from the beneficiary's future cash transfers. Forcing recipients to bear the cost of such medical treatments should create an *ex ante* incentive discouraging irresponsible behavior.

One could also develop hybrid approaches that focus on populations with known problems while letting individuals within those groups show they can be trusted. For example, mental illness and chemical dependency are unusually common among the homeless. A cash-oriented Medicaid program might give homeless persons vouchers to pay rent. Homeless persons who did well for a specified period could qualify to receive cash, replacing some or all of the value of the rent voucher.

Unsophisticated shopping would also be a problem. Because patients know less about medical treatments than providers, providers might try to sell them services that are overpriced, ineffective, or unnecessary. These are serious problems in our current defined-benefit programs. A cash-transfer program would make them less severe. As the retail market develops, providers would feel pressure to demonstrate the value of their services and the reason-

ableness of their prices. Advising services would also develop to help patients evaluate the accuracy of diagnoses, the appropriateness of treatment recommendations, and the reasonableness of fees.

Skeptics may argue that government involvement and oversight are essential because beneficiaries cannot look out for themselves. But converting Medicaid into a cash-transfer program would not prevent government agencies from certifying or monitoring nursing homes, assisted living centers, or home health agencies. It also would not prevent the government from throwing the book at the fraudsters and con artists who rip off the current defined-benefit Medicaid and Medicare programs. If government involvement in these areas adds value, it can continue. Second, because many poor people shop intelligently, less savvy

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beneficiaries can "free-ride" on their efforts. The idea is similar to that of choosing among unfamiliar restaurants according to whether their parking lots are empty or full. By following the crowd of people who shop intelligently, less able Medicaid and Medicare beneficiaries can secure good value for their money.

Finally, markets have distinct advantages over direct government regulation in ensuring that providers respond to consumer preferences. A dissatisfied nursing home resident currently can complain to a federal or state agency but has no control over the timing and substantive content of the agency's response. The threat of leaving the nursing home unless conditions improve is more direct and more effective. Nursing home residents will always have the option of voice, but we should not ignore the fact that the option of exit is often more powerful.

ECONOMIC GAINS

Our proposal would dramatically improve the efficiency of the health care sector by forcing providers to compete for customers who are spending their own money. The cost savings and quality improvements would be considerable, as providers scramble to serve patients better and more cheaply. Consumers who are spending their own money will refuse to buy medications and services that are overpriced, so excessive charges for medical treatments would quickly disappear. These price reductions disproportionately benefit poor people because they are the most price-sensitive consumers.

Reforming these programs would also save an enormous

amount of money—as much as one-third of the programs' combined budgets—by reducing fraud and waste. Medicaid, Medicare, and other government health care payors are easy targets for fraudsters because they rely on providers to bill truthfully. Consumers who are spending their own money would be much harder to cheat. They will not pay for services that were never delivered or were up-coded, and they will learn not to buy services that are unnecessary or ineffective. Administrative costs will decline because the claim-paying and bureaucratic rule-making infrastructure would no longer be needed. The process of determining eligibility and distributing money could be turned over to the Social Security Administration, which already handles Medicare enrollment.

The main risk with converting Medicaid and Medicare into cash-transfer programs is eligibility fraud. Both programs restrict eligibility—Medicare on the basis of age and Medicaid on the basis of income and wealth. It is predictable that some people who are ineligible for benefits will attempt to gain access to available funds or to increase their benefits by submitting false information. Also, if cash were available instead of medical services, people who currently are eligible for Medicaid and Medicare but who do not bother to apply might change their minds. Work disincentives may also be an issue for the subset of Medicaid beneficiaries who are of working age and not disabled.

The federal government's experience with Social Security and the EITC, both of which provide cash, help gauge the likely magnitude of these problems. For the EITC, the consensus is that errors account for most overpayments (and underpayments) and the amount of actual fraud in the program is fairly small. For traditional Social Security, the frequency of mistaken payments is remarkably low (0.4%), although estimates are materially higher for the disability insurance portion of Social Security.

The prudent course would be to expect fraud to happen and to prepare for it. Any plan to convert Medicaid and Medicare into transfer programs should include a significant antifraud component. But it should be easier to police fraud in cash-transfer programs than it is to ensure honesty in the sprawling programs we have today because the latter can be cheated by both providers and beneficiaries. A cash-transfer program would have to police providers far less than is currently the case.

Obviously, there would be significant issues in transitioning from our current defined-benefit approach to a defined-contribution approach. These transitional problems would be wrenching, but the current system is unsustainable. The longer we postpone taking steps to address the deficiencies in our current approach, the worse these problems will become.

CONCLUSION

Since Medicaid and Medicare were enacted in the mid-1960s, the United States has spent trillions paying for defined benefits on terms dictated by the health care sector. The results have been decidedly unimpressive. Our proposal to convert Medicaid and Medicare into defined-contribution/cash-transfer programs

modeled on Social Security recognizes that people generally know how to help themselves better than health care providers do. We should be giving money to Medicaid and Medicare beneficiaries and let them decide how to spend it.

Even though cash transfers would help poor Americans more than in-kind benefits, important program design questions will have to be addressed. Will the government dole out payments equally or will they vary on the basis of age, income, health status, or other factors? Will benefits be available to all poor adults or only those who are employed? Will money be deposited into restricted-use accounts or accounts from which withdrawals may be made for any purpose? How will eligibility fraud be policed? These questions and many others will have to be answered. As always, the devil is in the details.

Health care providers, who profit from existing arrangements, will vigorously oppose our proposed reform. They will use their considerable political influence to prevent politicians from giving beneficiaries control of the money. Paternalistic health policy experts, who believe that the government can help people better than people can help themselves, will also object. This coalition of “Bootleggers and Baptists” will continue to support Medicaid and Medicare in their current forms even though these programs do a rotten job serving the interests of their beneficiaries. After more than half a century of spiraling costs and mediocre service, it is time to make these programs work for their enrollees. R

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