MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

State legislators should

- reduce spending on Medicaid and the Children's Health Insurance Program (CHIP) whenever possible;
- refuse to implement the Medicaid expansion provisions of the Patient Protection and Affordable Care Act (i.e., Obamacare);
- conduct randomized, controlled experiments of the effects of Medicaid and CHIP with existing populations;
- reduce unmet medical need by deregulating medical care and health insurance; and
- demand that the federal government grant states flexibility with existing Medicaid and CHIP funds—not additional funds—to provide medical and long-term care to the needy.

Congress should

- eliminate or reform the tax exclusion for employer-sponsored health insurance;
- turn Medicare into a Social Security–like cash-transfer program;
- repeal Obamacare;
- deregulate health care and health insurance;
- permit states to conduct randomized, controlled experiments on the effects of Medicaid and CHIP coverage on existing populations;
- eliminate federal entitlements to Medicaid or CHIP benefits;
- freeze each state's Medicaid and CHIP funding at current-year levels;
- give states full flexibility to use Medicaid and CHIP funds to achieve a few broad goals; and
- begin phasing out Medicaid and CHIP federal funding.

The greatest economic safety net humans have devised is the market. A market system uses innovation to fill the cracks in the health care sector so that fewer vulnerable patients fall through with every passing day. It brings health care of ever-increasing quality within reach of an ever-increasing number of people. It drives prices for medical care and health insurance downward. It harnesses the self-interest of clinicians, administrators, insurers, and other patients to improve the quality of medical care and health insurance. It minimizes the problem of preexisting conditions.

When government tries to fill the cracks in the health sector, it creates new ones and causes existing cracks to widen. After decades of government's making medical care and health insurance more expensive with interventions like Medicare, the tax exclusion for employer-sponsored health insurance, and the licensing of clinicians and health insurance, far fewer low- and middle-income households can access health care than could in a market system.

Unfortunately, the government's response has been to intervene even further. As with Medicare, Congress created Medicaid and CHIP to solve problems that Congress itself either exacerbated or caused. Those programs have in turn further increased tax burdens and the cost of health care.

The most important thing policymakers can do to improve access to care for the poor is not to subsidize them. It is to liberalize the health care sector. Liberalizing the U.S. health care sector would do more to reduce unmet medical need than expanding or maintaining existing safety-net programs. It would make the problem of unmet need smaller and leave the rest of society wealthier and better able to help the shrinking number of patients who still could not help themselves.

The most important thing that policymakers can do to help the poor obtain health insurance and medical care is adopt policies that spur cost-saving innovations and lower prices. Falling prices do not involve a "Samaritan's dilemma." Whereas welfare can trap the poor in poverty; falling prices help them climb out. The reforms that would put the most downward pressure on health care prices are turning Medicare into a Social Security–like cash-transfer program (see "Medicare"), reforming the tax treatment of health care (see "Tax Treatment of Health Care"), and deregulating medicine (see "Health Care Regulation") and health insurance (see "Health Insurance Regulation").

In addition, federal and state governments operate three main programs to provide medical care to low-income Americans: Medicaid, the Children's Health Insurance Program (CHIP, previously the State Children's Health Insurance Program or SCHIP), and premium subsidies available through the health insurance "Exchanges" of the Patient Protection and Affordable Care Act. Congress should repeal or fundamentally reform each of these programs.

Medicaid

Medicaid spends $783 billion annually, ostensibly to provide health care to the poor. The federal government jointly administers Medicaid with state and territorial governments.

States that wish to participate in Medicaid must pay a portion of the cost of a federally mandated set of health benefits to a federally mandated population of eligible individuals. All states participate in the traditional Medicaid program, which primarily serves four low-income groups: mothers and their children, the disabled, the elderly, and those needing long-term care. Specific eligibility criteria vary by state, as does the exact rate at which the federal government matches state spending on Medicaid. Overall, the federal government finances 65 percent of total Medicaid outlays while states finance 35 percent.

In return for participating in Medicaid and financing a portion of program spending, each state receives matching federal funds to administer its program. When states spend money on mandatory populations—or make Medicaid benefits more comprehensive than the federal government requires or extend eligibility to more people than the federal government requires—the federal government matches what the state spends, seemingly without limit.

Obamacare gives states the option to expand their Medicaid programs to all adults with incomes below 138 percent of the federal poverty level. (The federal poverty level and Medicaid-expansion eligibility threshold rise with the number of household members and with time. As of 2022, the Medicaid-expansion eligibility threshold was $18,754 for single adults.) The principal beneficiaries of Obamacare's Medicaid expansion are able-bodied adults. Starting in 2014, the federal government paid 100 percent of the cost of a state's expansion population, gradually declining to 90 percent in 2020. Despite multiple attempts to sweeten the deal with additional federal matching funds, 12 states still refused to implement Obamacare's Medicaid expansion in 2022.

For beneficiaries, Medicaid is an entitlement. So long as they meet the eligibility criteria, they have a legally enforceable claim to benefits. People tend to cycle on and off Medicaid for various reasons. The federal government estimates that 81.5 million people will enroll in Medicaid during 2022.

Perverse Incentives

Financing Medicaid by having the federal government match state spending encourages fraud, creates perverse incentives for state officials, and encourages states to enroll people who don't need assistance. Because federal and state governments share the burden of Medicaid spending, neither side cares about waste, fraud, or induced dependence as much as they should care—or would care if either were to bear 100 percent of the cost.

The more a state spends on its Medicaid program, the more it receives in federal matching funds. When a state spends $1, it receives between $1 and $9. States can thus double, triple, or even receive a ninefold return when they devote state funds to Medicaid rather than other priorities like education or roads.

Medicaid's matching-grant system encourages stunning amounts of fraud. The Government Accountability Office consistently designates Medicaid as a "high-risk" program, estimating that "Medicaid improper payments represented 21.4 percent of federal program spending—more than $85 billion—in fiscal year 2020."

The system creates perverse incentives for state officials to stint on other priorities. Spending $1 on police buys $1 of police protection. Spending $1 on Medicaid, however, buys $2 to $10 of medical or long-term care. Medicaid rewards states for spending the marginal dollar on medical and long-term care even when spending it on police, education, or transportation would provide greater benefit.

It also encourages states to cut other priorities to protect Medicaid spending. Unlike the federal government, nearly all state legislatures face constitutional or statutory requirements that they balance their operating budgets each year. States that want to do so by reducing state spending must cut "old" Medicaid outlays by $2 million to $5 million or cut Medicaid expansion outlays by $10 million to achieve just $1 million of budgetary savings. Medicaid encourages states to cut spending on police, education, and transportation, where $1 million in budgetary savings requires only $1 million of political pain, rather than on Medicaid, where $1 million in budgetary savings requires inflicting $2 million to $10 million of political pain.

Obamacare's Medicaid expansion created additional perverse incentives to prioritize able-bodied adults over more-vulnerable enrollees. If states cut spending on mothers and children, the disabled, the elderly, and long-term care recipients, then achieving $1 million in budgetary savings requires inflicting $2 million of political pain. Achieving the same savings by cutting spending on able-bodied adults requires inflicting $10 million of political pain.

Medicaid both pulls and pushes enrollees into dependence. Medicaid pushes people into dependence on government for their health care by making private health care less affordable. Economists Mark Duggan of Stanford and Fiona Scott Morton of Yale found, for example, that Medicaid's system of setting drug prices increases prices for private payers by 13 percent. The more federal and state governments expand Medicaid, the more expensive private medical care and health insurance become. Medicaid pulls enrollees into dependence on government by offering a valuable subsidy that disappears as income rises. Enrollees often see little or no economic benefit to working harder and increas-

ing their incomes, which creates a powerful disincentive to becoming financially independent.

The State Children's Health Insurance Program

Congress created the State Children's Health Insurance Program in 1997 to expand health insurance coverage among children in families that earn too much to be eligible for Medicaid. The federal government funds each state's program much as it funds traditional Medicaid but with two main differences. First, states receive a larger federal match under CHIP than under traditional Medicaid. In 2022, the federal government will have financed at least 69 percent of the cost of each state's program. For every dollar that states invest in CHIP, they receive on average about $3 from the federal government (i.e., from taxpayers in other states).

Second, the federal government ostensibly limits the amount it will contribute to each state's program. But the cap is not as binding as it appears. States often burn through their federal CHIP funds before the end of the fiscal year and then demand additional funds. In effect, states *create* emergencies and then demand emergency funding, in effect daring Congress to deny their demands, which would strip coverage from sick children. Congress has repeatedly bailed out states that employ that gambit, which effectively rewards states for committing to spend more federal dollars than federal law allows.

As a result of these perverse incentives, states have expanded CHIP eligibility dramatically. Eighteen states and the District of Columbia offer CHIP to families of four with incomes of $83,000 or more. In New York, CHIP is available to families of four earning $112,000 annually. Because CHIP targets families higher up the income scale than Medicaid does, and because higher-income families are more likely to have health insurance to begin with, CHIP leads to an even greater "crowd-out" of private insurance than Medicaid.

Are Medicaid and CHIP Even Helping?

Remarkably, there is little reliable evidence that these programs have a net positive effect on health and absolutely no evidence that they are the best way to improve the health of targeted populations.

In 2008, the Oregon Health Insurance Experiment examined the effects of Medicaid by taking advantage of a policy that randomly assigned applicants to receive Medicaid or nothing and then comparing outcomes for the two groups. As it happens, the study examined a population that would receive coverage under Obamacare's Medicaid expansion. Random assignment made this experiment the most reliable study ever conducted on the effects of health

insurance. The authors found that Medicaid coverage "did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain." But even though researchers chose measures of physical health that should have been amenable to treatment over a two-year period, Medicaid enrollment "generated no significant improvements in measured physical health outcomes in the first 2 years." The lack of any improvement in physical health outcomes among Medicaid enrollees should throw a stop sign in front of Medicaid generally and Obamacare's Medicaid expansion in particular.

Similarly, there is no evidence that Medicaid is cost-effective. The Oregon Health Insurance Experiment did find small improvements in self-reported mental health. But not even that study attempted to quantify whether Medicaid is a cost-effective way of achieving those gains—that is, whether state and federal governments could have purchased better health by spending those funds differently or enacting different reforms. Federal and state governments should not continue to take trillions of dollars from taxpayers to support these programs when they don't even know what they are getting in return.

Whether or not Medicaid, CHIP, or Obamacare's premium subsidies turn out to improve health for some populations, or to be a cost-effective way of doing so, these programs become increasingly less cost-effective the higher up the income scale they reach. Higher-income households have higher baseline access to health insurance and medical care. As these programs move up the income scale, they offer taxpayer-financed coverage to increasing numbers of people who already had private insurance. One study by Obamacare supporters estimated that the law's Medicaid expansion would lead to "high rates of crowd-out for Medicaid expansions aimed at working adults (82 percent), suggesting that the Medicaid expansion provisions . . . will shift workers and their families from private to public insurance without reducing the number of uninsured very much." That estimate suggests that Obamacare's Medicaid expansion could be covering fewer than 2 previously uninsured Americans for the price of 10.

Determine Whether Medicaid Actually Helps

Rather than expand Medicaid, federal and state policymakers should conduct further experiments to determine what benefits Medicaid and CHIP actually produce and whether other uses of those funds would produce greater gains in health and financial security. Policymakers should model these studies on the Oregon Health Insurance Experiment. States should conduct these studies with existing populations rather than new enrollees, so as not to impose additional burdens on taxpayers.

The federal government should grant waivers to states that conduct such studies. Where federal law does not provide authority for the secretary of health and human services to approve such waivers, Congress should grant it or enact legislation directly approving such studies.

Block Obamacare's Medicaid Expansion

States that have implemented Obamacare's Medicaid expansion are buckling under the expense. In those states, enrollment and per-enrollee spending have exceeded projections.

The 12 states that have still refused to implement Obamacare's Medicaid expansion in 2022 should continue to refuse. The 38 states that have implemented it should withdraw from the program—or at least conduct randomized experiments to determine what the program is delivering.

Repeal Obamacare

Congress should repeal Obamacare's Medicaid expansion along with the rest of the law. Repealing the Medicaid expansion alone would reduce federal spending and deficits by $1.4 trillion from 2022 through 2031 and eliminate the low-wage trap that the program creates. Repealing the remainder of Obamacare would eliminate the low-wage traps its Exchange subsidies create and reduce federal spending and deficits by a further $848 billion, while also reducing the cost of private health insurance for the vast majority of enrollees in those programs.

If the Medicaid expansion were popular, states would be willing to pay for it themselves. Not only did 0 states take that step, but 12 states have rejected it even with Congress pledging to pick up 90 percent of the tab. States that have rejected the Medicaid expansion have reduced federal spending, federal deficits, and the future tax burden of taxpayers in *all* states, saving taxpayers hundreds of billions of dollars. It is unfair to force taxpayers in states that have rejected the Medicaid expansion to pay for the expansion in other states.

Medicaid and CHIP

Repealing Obamacare is not enough, however. It makes little sense for taxpayers to send money to Washington only for Congress to send those funds back to their state capitols with strings and perverse incentives attached. Congress should devolve control over Medicaid and CHIP to the states.

In 1996, Congress eliminated the federal entitlement to a welfare check, placed a five-year limit on cash assistance, and froze federal spending on such assistance. It then distributed those funds to the states in the form of block

grants with fewer federal restrictions. The results were unquestionably positive. Welfare rolls were cut in half, and poverty reached the lowest point in a generation.

The federal government should emulate that success by eliminating all federal entitlements to Medicaid and CHIP benefits, freezing federal Medicaid and CHIP spending at current levels, and distributing those funds to the states as unrestricted block grants. Block grants like those Congress used to reform cash assistance would eliminate the perverse incentives that induce dependence, favor Medicaid and CHIP spending over other priorities, lead states to tolerate widespread fraud, and encourage states themselves to defraud federal taxpayers. Congressional Budget Office projections indicate that simply freezing remaining federal Medicaid and CHIP spending at 2022 levels would produce $247 billion in savings and deficit reduction by 2032.

With full flexibility and full responsibility for the marginal Medicaid dollar, states could then decide whether and how to navigate the Samaritan's dilemma. States that want to focus only on their neediest residents could do so and put the savings toward other priorities or tax reduction. States that want to spend more on their Medicaid programs would be free to raise taxes to do so, and vice versa. States would learn from the successes and failures of each other's experiments. Since states would bear the full marginal cost of their reformed Medicaid programs or successor programs, they would be more likely to conduct randomized, controlled experiments to determine the most cost-effective uses of those funds.

Over time, the federal government should give the states full responsibility for Medicaid by eliminating federal Medicaid spending while concomitantly cutting federal taxes. States can hasten these reforms by pressuring the federal government for maximum flexibility in administering their Medicaid programs.

Suggested Readings

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